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by

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Early Interventions to Trauma: An Examination of Crisis Support Delivery, Trauma Clinician Skill Development, and Potential Applications for Child Welfare Apprehension and Placement

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Abstract

This advanced practicum thesis presents a Master of Social Work student's journey toward becoming a more skilled trauma clinician. It also serves as a forum to consider opportunities to limit or reduce trauma potentially suffered by clients through their engagement in my current field of social work practice, child welfare. This practicum was completed with the Victim Crisis Unit (VCU), a division of the Ottawa Police Services. The Victim Crisis Unit is devoted to providing emergency service provision to Ottawa residents exposed to trauma or criminal victimization. Three primary goals were developed for this practicum experience. The first goal was to gain, through experiential learning, the ability to practice ethically sound, effective, Early Intervention (EI) techniques targeted at mitigating the negative effects of victimization and trauma. The second goal was to make an overall improvement to my capacity as a trauma clinician by developing my therapeutic presence, client-engagement, self-awareness, and professional self-care through learning about mindfulness research and practice. My third goal was to reflect on the combination of my research and experiential learning in order to present a critical analysis of the potential applications of EI techniques for child welfare practice, most specifically, how they might make the process of bringing children into care more trauma-informed and less damaging.

Acknowledgement

Many endeavors are undertaken with a finish line in mind. Through my pursuit of my Masters of Social Work, I've come to recognize, however, that the true rewards and adventure are found in the journey. Accordingly, I'd like to express my sincerest gratitude to those that contributed to this journey from beginning to end. I owe my utmost appreciation to my first and second readers, Dr. Diana Coholic and Dr. Leigh MacEwan, for their encouragement, persistence, and guidance, without which I would not have realized this goal. I would also like to express my deepest appreciation for the warmth, openness, and inspiration that I received from the Ottawa Victim's Services Unit. In particular to my practicum advisors, Ms. Eva Savage and Ms. Traci Brown, I could never have anticipating how incredibly invigorating and fulfilling getting to know and learn from each one of you would be. To my fellow classmates, Jennifer Tremblay and Celine Ouellette, the laughs, tears, struggles, and friendships are my most vivid memories of this experience and those that I'll treasure most. Lastly, I would like to offer my final thanks to my parents for disproving that you 'can never go home again' and to my friends for their countless acts of encouragement and sacrifice which were offered freely and without hesitation.

In closing, I'd like to offer this thesis in dedication to the memory of two of the most amazingly ambitious women that I've had the honour of knowing; Ms. Krista Johnson and Mrs. Muriel Lackey; I'm forever bettered and strengthened for having had you in my life.

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Introduction

Social workers practice with clients who have suffered trauma in many capacities. Like the clients themselves, the variations of trauma are innumerable and distinctive. I have spent the first decade of my career working with vulnerable, often traumatized, children in the child welfare system. This work has afforded me the opportunity to work within long-term clinical relationships with clients. These relationships have been the setting in which I have learned to offer support for trauma experiences. As a clinician, I have had considerably less opportunity to act in a therapeutic role with those who have been traumatized at the point of that trauma; or perhaps more accurately stated, the child welfare system fails in its design to facilitate awareness or expectation to intervene at that time. I found the lack of appropriate, timely intervention increasingly concerning as I began to consider the potential trauma that our child welfare system inflicts on its clients who are vulnerable, traumatized children.

It is likely inevitable that there will always be circumstances that will require that children be removed from their families in order to address or prevent further harm. This reality, however, does not negate the fact that the apprehension, in and of itself, can be yet another trauma. Triggered by my consideration of these systemic weaknesses, I began to self-examine the adequacy and efficacy of my support to these children through the processes of apprehension and placement. I realized that I had only the most general, common-sense social work techniques for offering support. I had no empirical understanding of what might be most effective or how to tailor those interventions to the particular client that I was engaging with.

It is rare to know when, where, and how a potentially traumatizing experience is going to happen. It is even rarer that a professionally trained social worker would be there for this occurrence. It seems counterintuitive that a social worker would be passively present for a

trauma let alone inflicting it. Yet, in many cases, when children are apprehended from their parents, this is exactly what happens – a scheduled, planned, and social work supervised potentially traumatic experience. Considering the uniqueness of this situation made me reflect on the potential opportunities I had missed to help clients mitigate the debilitating impacts of the trauma that we, as a system, were potentially creating. Furthermore, and more critical to my professional self-concept, it led me to question in what ways I might have inadvertently contributed to this traumatic experience. These considerations inspired me to undertake this advanced practicum as a means to improve my ability to offer trauma-informed, evidenced-based support through crisis that is more empowering, ethical, individualized, and effective. My journey in pursuit of this goal is presented in this thesis document.

This document begins with a presentation of the relevant literature. Three literature reviews are presented which work in collaboration to help support my foundational knowledge. The first two of these reviews focuses on the current literature relating to victims of crime and early interventions to trauma, and the second on mindfulness and social work practice. The understanding that I gained helped to prepare me for my placement with the Ottawa Police Services' (OPS) Victim's Crisis Unit. The final literature review, which considers the potential negative impacts of the child welfare system, was undertaken to facilitate my critical analysis and reflection on improving this system's sensitivity to trauma.

In the second chapter, I present a detailed description of the OPS' Victim's Crisis Unit and its function. I then define my three primary learning goals in detail and provide explanation for how they were pursued in the placement context. The third chapter then presents an account of the most impactful and meaningful experiences and learning opportunities that I was fortunate enough to have during the completion of my practicum with the Victim Crisis Unit. The fourth

chapter presents my attempt to relate this learning opportunity to my own daily professional social work practice in child welfare. It contains a critical analysis of the potential opportunities for early interventions to trauma to reduce the proposed unintentional, negative impacts of the apprehension and placement of children in the child welfare system.

To conclude the document, I provide a consideration of the ethical implications of both the undertaking of the practicum experience itself and the assertions that I proposed in this document. I also offer an exploration of the limitations of this thesis both with regard to the propositions that I have made concerning the future of child welfare and with regard to the limitations of my skills and experience as a social worker. Finally, I supply a succinct conclusion of the information provided in this document and my reflections on this personal and professional endeavor.

Chapter One

Grounding Trauma Practice in Empirical Research: A Review of the Current Literature

I reviewed three primary areas of literature in preparation for this advance practicum: victims of crime and early interventions to trauma, mindfulness and social work, and the consequences of child welfare apprehension and placement. The results of each review along with the specific search terms and databases used are presented separately in the interest of clarity. The first section of the literature review is focused on social work with victims of crime and the early interventions to trauma implemented to intervene with this population. The main purpose of this section is to ensure my preparation to provide support to victims of crime and traumatic experiences which was the primary responsibility of my advanced practicum with the Victims' Crisis Unit. The second section of this literature review focused on the incorporation of mindfulness in social work practice. This body of research was examined for a dual purpose, first to improve my capacity for therapeutic presence and engagement in a trauma-driven social work role and second to establish and nurture a strong foundation of self-care. The final section of the literature review focused on the current research regarding the potential traumatic consequences of child welfare involvement for children, most specifically the impact of apprehension and placement in alternate care. While the purpose of the first two sections related directly to my execution of my practicum placement, the purpose of this final section was to set the foundation for my analysis of how I might integrate my practicum learning experience into my full-time work as a child protection worker.

Early Interventions to Trauma with Victims of Crime

I initiated this literature search on the Laurentian University Library via the Social Work Abstracts, Social Science Abstract, and PsycARTICLES databases. I began with the search terms

'social work', 'victims of crime' and 'early interventions with victims of crime', 'early interventions to trauma', and 'victim's services'. These searches provided a significant number of results. Some of the results pertained only to victims of crime, some only to early interventions to trauma, and some were particularly useful as they intersected both topics. Literature was reviewed so long as it was relevant to one of the primary areas of research. This decision was made in order to determine whether there were other preferred methods of intervention. No specific parameters or legal requirements were assigned to 'victim of crime'; neither were 'victims' categorized or reviewed by the type of crime they suffered. Further, no specific parameters were defined for trauma, both 'acute' and 'chronic' trauma was deemed acceptable. Results were limited by their date of print (less than 10 years old) and were required to be from peer-reviewed journals. Some older sources were maintained if they were referenced in a particularly pertinent article. Efforts were made to ensure that these articles were used only in moderation in order that the literature reflected the current state and trends in working with victims of crime and early interventions to trauma.

The majority of the research findings dealt primarily with working with victims of crime or early interventions to trauma. For this reason, this literature review is presented divided into these broad categories in order to allow for the greatest transparency and clarity in presenting trends and themes across the articles.

Victims of Crime

The 1990s ushered in a worldwide 'explosion' of the victim's rights movement. Victims of crime were no longer a peripheral concern on the fringe of the criminal justices system. After this movement, their interests were much more central to the investigation and court process resulting in a parallel expansion and professionalization of the resources and services available

(McBrearty, 2011; Williams, 1999). Academia also began to devote much greater attention to victims of crime (Sims, Yost & Abbott, 2006). The research findings on working with victims of crime gathered under the above defined conditions can be most broadly organized into three major categories, those categorizing and defining the population of victims of crime (Green, 2007; Ljungwald & Svensson, 2007; McBrearty, 2011, Sims et al., 2006), those involving the institutions and organizations under which services are offered (Cooper, Anaf, & Bowden, 2008; Flemming, Goodman, Knight, & Skinner, 2006; Ljungwald & Svensson, 2007; Shepherd & Lisles, 1998), and finally those relating to the direct social work skills required for practice in this field (Cooper et al., 2008; Hill, 2013; Williams, 1999).

Findings on the population. Most researchers agreed that while everyone could be a victim of a criminal offence, some populations including the mentally ill, the impoverished, and other marginalized populations were much more likely to be victimized (Green, 2007; Ljungwald & Svensson, 2007; McBrearty, 2011, Sims et al., 2006). Further, it appeared that, with each subsequent victimization, the likelihood of another increased (Amstadter, McCart, & Ruggiero, 2007; Green, 2007; Ljungwald & Svensson, 2007; McBrearty, 2011, Sims et al., 2006). Victims of crime, in comparison to those that have suffered other forms of trauma, are more likely to experience multiple victimizations spread across their lifespan. For instance, a child who has lost a parent at an early age would not necessarily be at increased risk for trauma later in life, while victims of crime are at a higher likelihood of being re-victimized. Unlike other groups, victims of crime are less likely to have suffered multiple incidents of the same trauma or otherwise stated, they tend to show an increased risk to a variety of different traumatic experiences (Amstadter et al., 2007). Not surprisingly, findings also indicated that the likelihood of psychological difficulties due to trauma followed a similar trajectory. Sims et al. (2006) found

that individual 'coping skills' were the most predominant factor in determining whether or not a mental health diagnosis was implied. This same research tied coping skills to individual characteristics and natural support systems (Sims et al., 2006).

One of the most poignant findings that transect each of the three primary trends in victims of crime research is the identification of the concept of the 'perfect victim.' This concept refers to the tendency amongst professionals (social workers, police, social service workers, etc.) to recognize an individual as a 'victim' only if they are completely free of culpability. The fact that they have been transgressed upon is not considered sufficient to aforementioned professionals (Cooper, Anaf, & Bowden, 2008). Due to the power and authority held by professionals, this determination of 'worthiness' as a victim has varied but great impact. As related to social work practice, it can lead to discrimination in the provision or quality of service (Ljungwald & Svensson, 2007). Within law enforcement, police have been found to offer less commitment in encouraging un-worthy victims of various crimes to seek criminal charges, felt less invested in connecting them to supportive community resources, and were less apt to place value in the potential costs to a victim and/or witness in pursuit of the criminal conviction (Cooper et al., 2008).

Environment of service delivery. The above example adeptly introduces the core of the second area of research focus, service delivery. With the expansion of the victim's interests in the criminal justice system, a new philosophy regarding serving this population was also introduced: a shift to multisystem service delivery (Cooper et al., 2008; Flemming et al., 2006, Shepherd & Lisles, 1998). This new approach has resulted in an increased need for social workers to work collaboratively with police and other professions (Cooper et al., 2008; Flemming et al., 2006; Ljungwald & Svensson, 2007). As a consequence, a considerable amount

of role confusion for professionals has occurred (Cooper et al., 2008; Ljungwald & Svensson, 2007). For instance between police officers and social workers, it has repeatedly been found that communication is poor and that a significant number of victims are going unnoticed or unattended because of this divisive approach (McBrearty, 2011).

Social worker skill set. The literature on victims of crime also provided a considerable amount of focus on the skills of the practitioner and direction as to how he or she ought to engage with this group. Victims of crime share many commonalities with other vulnerable groups, and a great deal of the literature written to educate and guide social workers for practice with this population focuses on these issues. Being criminally victimized can lead people to react with feelings of distrust, anxiety, and worries about stigmatization (Amstadter et al., 2007). This presentation can make clients fragile and particularly hesitant to engage (Hill, 2013), therefore requiring an even greater capacity for rapport and trust building skills on the part of the clinician. As indicated in the above discussion entitled on 'Findings on the population', the ability to support the client's natural internal and social supports will be critical to client success.

Researchers working in this area also spent considerable time addressing an element of social work skill that is not directly related to clients: self-care. For example, Hill's research (2013) shows elevated levels of anxiety, anger, and frustration in social workers who work with victims of crime. These impacts are connected to the cost of working in situations of crisis with individuals who are experiencing significant trauma and loss. Hill (2013) outlined a number of important ways in which a social worker can ensure that they are taking appropriate care of themselves as humans and as clinicians. Specifically, social workers should ensure that they maintain appropriate boundaries, have sufficient peer support, maintain current education on the population with whom they are working, and maintain an on-going process of self-reflection and

assessment (Hill, 2013).

As illustrated above, it is well established that criminal victimization leads to trauma. In fact, Amstadter et al (2007) found that crime victimization tends to be more closely linked to PTSD than other traumatic event. This is particularly true if there is no issue of intentionality in the crime (e.g. car accidents). With the establishment of the link between criminal victimization and the psychological impacts of trauma, my next logical step was to attempt to explore the literature on best-practice for intervening at the time of these traumatic experiences.

Early Interventions and Trauma

The need for early interventions to trauma has predominately grown out of the increase of man-made (terror) and natural disasters. These incidents simultaneously expose large groups of people to horrific and tragic experiences associated with a variety of mental health consequences. A well-intentioned, movement grew to provide services to these individuals, many times beginning right at the scene of the experience. However, the rapid development of this intervention strategy didn't undergo any systematic review until well after it was in practice. The initial findings would cast considerable concern, which then initiated retaliation from supporters. This controversy has been (and remains) central to EI research.

From my analysis of the literature two primary areas of debate emerge: variability in 'definition' and in 'timing'. First, there appears to be a considerable amount of disagreement about exactly what early interventions are and what they are intended to accomplish. Strangely, authors who argue the merits of early intervention strategies seem to accept many of the same arguments put forth by critics. First, they are quite clear that EI are not therapy, nor do they purport to be (Devilly et al., 2006). Advocates of EI strategies explain that they should not be confused with 'therapy'; they are, rather, a set of directions to emergency workers who interact

with recently traumatized people (Devilly et al., 2006). From my examination of the literature, I am uncertain where the assumption that EI were to be a form of therapy was first initiated. Used properly, EI strategies for trauma should be 'psychological first aid'; no more, no less. This term of 'psychological first aid', which has become common language in the EI field, provides some insight into the service provided. First and foremost, these interventions begin with an assessment of risk and needs (McNally, Bryant, Ehlers, 2003). Assessments should go beyond just current pathology; they need to include immediate needs and future risk. This is particularly true with trauma because (as described previously) there is an increased likelihood of diagnosis with a history of past trauma (Amstadter et al., 2007). One of the most important determinations to be made by the assessment is safety and security (e.g., food, shelter, attending to physical injuries, etc.). Typically this will be based on immediate circumstances; but as with all aspects of EI techniques, they must be adapted to the situation at hand (Dyregov and Rebel, 2012).

Proponents also argue that central to this trauma intervention is that it is client-lead and individualized. The client will guide most of the interactions, conversations, and interventions. Perhaps as central to the debate regarding what ought to be included in EI interventions in trauma, are assertions about what must not. Discussions regarding overly emotional and/or graphic details of the event are never to be introduced by the clinician (Devilly et al.,2006; Dyregov & Rebel, 2012; Mayou et al., 2000); however, some accommodation to this rule might be allowed for subject matter introduced by the client. Finally, a psycho-educational component is usually part of EI interventions (Devilly et al. ,2006; Dyregov and Rebel, 2012). Education might come in the form of normalization of the symptoms experienced by the traumatized individual or providing information and connections to resources in the community (housing, medical treatment, etc.) (Roberts & Everly, 2006; Phipps, Byrne, & Deane, 2007). Even at this

level of detailed examination, there is again agreement between those who support and those who object to EI techniques. Mayou et al. (2000), who suggested negative effects of EI, agreed with research by Devilly, Gist, and Cotton (2006) and Dyregov and Rebel (2012) which asserted that these interventions should be practical, individualized, and focused on meeting immediate needs.

Beyond the mechanisms of EI, the confusion and disagreement is further compounded by the tendency of critics to group all EI techniques together in spite of considerable variation amongst them. For instance, for some researchers terms such as 'psychological debriefing' have become synonymous with EI (Mayou et al., 2000). Yet, in reality, this is only one form of EI strategy. Furthermore, psychological debriefings are one form of EI strategy that many supporters of EI agree can have deleterious effects. Dyregov and Regel (2012) reported that interventions such as Crisis Intervention Stress Management (CISM) can be harmful. In fact, it is possible that, by design, this form of EI strategy conflicts with their requirements for effective early intervention. Briefly stated, these interventions might be considered to violate the principle of voluntariness as they are usually arranged by an employer or other agency that has some authority over those receiving support. For example, after a workplace accident, these sessions are likely to be provided during work hours, potentially undermining the individual's sense of being able to refuse service without ramification. Additionally, these interventions also typically occur in group formats with poor clinician to participant ratio. This considerably compromises the ability of interventionists to monitor the safety, responses, and discussions of participants (Dyregrov & Regel, 2012).

The second of the main areas of debate centers on timing. As highlighted by Devilly, Gist, and Cotton (2006), there is considerable variation in what is regarded 'early' after the

occurrence of a trauma. Here, there is perhaps more actual disagreement than in the previous discussion of the definition of EI; however, there is still considerable disagreement amongst researchers regarding the ideal point in time to introduce EIs. From the literature I reviewed, 'early' varied from mere hours after a traumatic event up to, and including, therapies that were initiated months after. The desirability of 'very' early intervention also seems to be echoed by findings by both Ehlers and Clark (2003) and Gray and Litz (2005) both of whom found that individuals who have shown PTSD-like symptoms displayed soon after a traumatic event are a strong indicator of a later formal diagnosis. Ehlers and Clark (2003) found a positive correlation with PTSD, while Gray and Litz (2005) found a similar relationship for those who will later receive an ASD (Acute Stress Disorder) diagnosis. This makes the ability to identify and intervene early before full diagnostic levels and life impact highly desirable.

Some portion of the debate described above can be attributed to the deficits in the current research. The weaknesses in the current research appear to fall broadly into three categories. The first area of deficit related to methodology. Many of the researchers identified that the studies available poorly defined the exact methods/interventions implemented, did not specify researcher qualifications or expertise, and lacked randomized trials (Ehlers & Clark, 2003; Forneris et al., 2013; Gray & Litz, 2006). The second area of weakness in the current research is the overly narrow focus on PTSD symptomology. Unfortunately, experiencing trauma is related to a variety of negative psychological ramifications. Post- traumatic stress disorder is common; however, it is not the exclusive consequence. Traumatic grief, depression, and anxiety disorders are also frequently diagnosed (Litz, 2008; Solomon & Heide, 1999). Yet the literature excludes these almost entirely. It is likely that the debate about EI would be much better informed if treatment of these disorders were also evaluated. Lastly, there is agreement between researchers, both for

and against EI techniques, that all interventions ought to be individualized to the client (Balaban, 2006; Cohen, 2003). Yet, there is a considerable lack of study of how many demographic variables might inform practice. For instance, I was not able to locate any research on the impact of culture or religion on early interventions with trauma. The research has already informed us that the mental health of victims of crime (who have been traumatized) depends heavily on personal characteristics and natural support systems (Amstadter et al., 2007; Devilly et al., 2006). Yet, without proper research-informed guidance on how to use personal characteristics such as culture and religion in the EI, these valuable pieces of information cannot be used to inform practice, which can compromise the social worker's ability to support their client in engaging natural support systems and personal assets.

Above, I have provided a broad overview of the literature that I have reviewed in preparation for my advanced practicum placement. While the research was a significant learning exercise in itself, I feel that to truly integrate this theoretical learning into my practice in a skilled and ethically sound manner, it is imperative that I have the opportunity to see these models practiced by experienced professionals, and later, to have the opportunity to utilize them personally in a supportive and guided setting. To achieve this goal, I have identified the Victim Crisis Unit of the Ottawa Police Service as an ideal training environment.

My desire to work in a stressful, trauma-filled area of practice also motivated me to attend to my personal and professional preparedness for this new challenge. I was introduced to Mindfulness through my course work at Laurentian University and learned that it might offer a proactive way to ensure my own wellbeing and a parallel benefit to my ability to intervene with clients. In the next section, I have compiled the literature that I reviewed on Mindfulness in pursuit of this goal.

Mindfulness and Social Work: Literature Review and Synthesis

The literature review on mindfulness was undertaken with the broad search terms 'mindfulness', 'social work', and 'prevention.' While I had an understanding that mindfulness had application both in social work practice and for self-care, my knowledge was so limited on the topic that I wanted to ensure that I did not bias my findings by specifying terms any further. As with the previous literature review, the search was initiated on the Laurentian University Library website. I focused on the Social Work Abstracts, Social Science Abstract, and PsycARTICLES databases. Resources were chosen from within the results based on their ability to connect both mindfulness and social work practice. In addition to journal articles, my literature review for mindfulness also incorporated resources (books and audio CDs) by Hicks (2009), Hicks and Bien (2010) and by Kabat-Zin (1994, 2006). These were selected due to the authors' level of expertise and knowledge on mindfulness. The findings of the literature review undertaken are presented below.

Defining Mindfulness

The choice of the present participle form of the verb 'define' was purposefully chosen over the past tense in order to properly capture the on-going evolution of mindfulness and its practice. Certainly there are many core elements which are central to mindfulness practice, along with some variation dependent on personal philosophy and the origin of one's practice. But, as mindfulness gains popularity and exposure in many academic fields of study (psychology, social work, healthcare, etc.) the breadth and depth of knowledge about it is growing exponentially.

One of the most succinct definitions of mindfulness was presented by George (2009) who wrote that "mindfulness is undefended consciousness" (George, 2009, p.162). John Kabat-Zinn, also renowned for his work in mindfulness, offers that to be mindful is to be fully present in the

current moment without judgment or efforts to change it in any way (Kabat-Zinn, 1994). I've simplified the definitions here to get to the very essence of the practice. To accurately capture mindfulness, it is also critical to understand what it is not. Mindfulness is commonly confused with a sense of having complete calm and oneness, a sort of control over one's environment reached through countless hours of meditation. Mindfulness is most definitely not about controlling the present moment. It is about the ability to recognize and accept it for all that it is and is not. Mindfulness is about simply being (Hick, 2009).

Mindfulness and Social Work

It has only been within the past decade that social work has begun to formally explore mindfulness through research and publication (Hick, 2009). It is important to introduce at this stage that after considerable consideration, it has been established with reasonable certainty that social workers ought to be committed to their own personal practice of mindfulness if they are going to rely upon its principles in their social work practice. This is particularly critical if they are going to instruct and support their clientele on how to incorporate mindfulness into their own lives (George, 2009; Graham & Graham, 2009). However, this does not mean that all social workers who practice mindfulness in order to reap the benefits in their personal and/or professional lives will educate clients on its practice for their own personal use. This decision remains at the discretion of the social worker and is usually based on their level of comfort and their assessment of its appropriateness for a particular client. This principle simply reinforces that in order to gain the benefits of mindfulness in social work practice it is insufficient to rely solely on an academic understanding. Mindfulness can influence social work practice primarily in three different manners: self-care; direct interventions with clients; and for the promotion of

social justice issues, which are central to social work as a discipline. These topics are discussed next.

Professional Self-Care: An Individual and Institutional Responsibility

The emotional and physical toll that human services can take on its employees (and even its students) is well-documented by those involved and supported by research (Berceli & Napoli, 2007; Napoli & Bonifas, 2011; Pipe, Brotz, & Dueck, 2011). In all helping professions, secondary trauma and burnout are legitimate realities, particularly for people whose daily work serves those who have suffered trauma (Kessen, 2009). The effects of secondary or vicarious trauma can present in people in variety of ways, including increased head and stomach aches, lowered self-esteem, emotional-numbing, and increased cynicism (VanDeusen &Way, 2006; Pack, 2011; Pogue & Yarborough, 2003). It has also been shown to compromise social workers' professional practice by eroding their capacity for empathy and leading to the depersonalization of clients (Tehrani, 2011). This is particularly upsetting when research shows extremely promising results about the potential for mindfulness to offer both preventative and reparative benefits for a wide variety of helping professionals.

Berceli and Napoli (2007) provided research that offers concrete trauma releasing exercises that are shown to be effective in supporting both the mind and the physical body process the impact of stressful events The intervention technique involved placing individuals in specific positions which trigger muscle trembling. The trembling of the muscles was used to help the body process the fear associated with a traumatic event which contributes to the prevention of PTSD symptoms. These tremoring behaviours are still observed in animals and are believed to have been used historically by humans as well. Berceli and Napoli (2007) proposed that these exercises could be incorporated into a broader mindfulness-based treatment plan. In their

proposed integrated treatment approach, mindfulness breathing and body scan exercises would be used to establish a foundation of emotional and physical connectedness and presence in the moment. Once this was established, mindful-breathing would be continued throughout the tremoring exercise routine. Practicing mindfulness would help clients to develop the capacity to accept and stay 'present' in their emotional and physical experiences without attempting to change and/or avoid them. The researchers indicated that these 'avoidant-type' behaviors are habitual for PTSD sufferers. Their mindfulness-tremoring approach would offer the combined benefits of extinguishing these habitual behaviours while providing the opportunity for the physical exercises to process the trauma physically through the body (Breceli & Napoli, 2007).

Affording professional helpers the opportunity to process the traumatic events that they are exposed to as a result of their work can be critical in terms of their ability to attend to their clients, and to feel that they have the personal resources to continue to face the work (Gehart & McCollum, 2010). Along these lines, Pipe, Bortz, and Dueck (2009), presented research conducted with nurses that provided a mindfulness-based program intended to reduce their experiences of stress and anxiety related to patient cases. The findings from the nurses in the 'treatment' group were so positive that the researchers determined that it would be unethical to deny other research participants access, and as a result, they ended their formal study in order to provide instruction to all participants.

Gathering such evidence, across multiple study designs/interventions and a variety of professions (social workers, students, nurses), compounds the power, legitimacy, and importance of such opportunities. However, the high degree of structure in these study designs highlights another important factor. Professionals must have the time and the opportunity to learn and participate in such trainings. In each of the studies above, time away from regular duties such as

studying and/or work were provided in order to create the opportunity for the necessary instruction and support to learn mindfulness techniques and exercises. Allotting work or school time for this purpose acts as an institutional affirmation and sanction. It is reasonable to suggest that such opportunities will also be necessary in real life situations to garner the benefits of learning mindfulness.

For the full benefit of mindfulness interventions to be realized, there must be a duality in duty both on the individual and on the employer. Birnbaum (2009) captured the root of this dual responsibility as it relates to social work with a very astute observation. She articulated that in social work, perhaps more than all other disciplines, it is essential that our individual practices and institutions reflect the values that we hold for our clients (Birnbaum, 2009). It is my perspective that social workers must live the principles that they demand of their clients; they need to be living examples. Self-care is critical not only to this living-example but also to maintaining the most effective resources possible for their clients. George (2009) suggests that a social worker's capacity to empathize with their clients can be significantly blocked due to inadequate attention to their own experiences of victimization. This victimization might occur as a result their own personal life experiences, but it might also, as is discussed above, be a result of their professional work and the systems under which they work. Based on my analysis, it is this increased professional risk for harm that clearly reflects the necessity of both individual awareness and self-care, as well as the support of the agency on behalf of whom the work is being completed.

The responsibility of the institutional obligation is particularly important for students or new social workers (or other helping professionals) who are more vulnerable and who may not have the awareness or the practical knowledge of how to protect themselves from the potential

negative consequences of this type of work. For many social work students, their first exposure to trauma and difficult case material begins in their education (Napoli & Bonifas, 2011). They are largely unequipped to deal with this exposure and the compounded expectations to learn and gain new skills can be overwhelming and undermining (Birnbaum, 2009; Napoli & Bonifas, 2011). Napoli and Bonifas (2011) addressed the benefits of mindfulness for social work students and social work curriculum in their research. Napoli and Bonifas (2011) also argued for the benefits of integrating mindfulness because it not only provides opportunity for instruction on gaining skills such as empathy and listening, which are essential for strong social work (and are quite poorly attended to in current curriculum according to these authors), but it also builds a foundation for social workers who know how to be gentle with themselves and practice good self-care.

While mindfulness can affect wellness directly by attending to some of the damaging effects of secondary exposure to trauma and harm as described above, it can also support preventatively by building self-confidence and feelings of professional capacity about entering this difficult field. If the field of social work can develop a skill set within social workers, which can act to insulate them against the suffering that they can incur as a result of their jobs, the helping field (clients and workers) as a whole benefits (Thielman & Cacciatore, 2014). For instance, mindfulness practice is also found to be positively correlated with compassion satisfaction, which is defined as the capacity to receive fulfillment through caregiving (Ray, Wong, White, & Heaslip, 2013) McGarricle and Walsh (2011) offered both quantitative and qualitative data to support that perceived stress was inversely related to the use of mindfulness practices for participants. This would suggest that rather than just being able to compensate for the negative side effects of this demanding work, mindfulness actually may have the ability to

provide a bolstering type of effect with regard to job satisfaction. Social work students who practice mindfulness were more attuned to their own needs and were more apt to practice good self-care habits (McGarricle &Walsh, 2011). To me, it follows logically that students, whose own physical, emotional, and psychological needs are met, might interpret work challenges through a more positive lens. Not only would they feel less stress at the challenges with which they are faced, but they might be likely to have a more positive outlook overall.

Mindfulness and Practice with Clients

The benefits of mindfulness in social work extend beyond nurturing stronger, more resilient social workers. A review of the current literature also suggests considerable overlap between the skills that mindfulness develops and those skills that are critical to high-quality social work practice. These direct practice benefits are explored below from both sides of the therapist-client dyad. First, the manner in which social work practice is improved is discussed in detail. These skills center primarily on those that underlie the essence of a therapeutic relationship or rapport (Beres, 2009; Hick, 2010; Lysack, 2010). The discussion then turns to those skills which can be imparted to the client by the social worker through their support and encouragement of the client's own mindfulness practice.

The single most important variable determining the success of therapy is the relationship with the clinician (Hick, 2010; George, 2009; Lambert & Simon, 2010). It is therefore exceptionally fruitful to understand what contributes or erodes this rapport between client and clinician. Many of the experts collected by Hick and Bien to contribute to the book *Mindfulness and the Therapeutic Relationship* identified that the most critical variable to building this strong connection between clinician and client is empathy (Bien, 2009; Lambert & Simon, 2010; Walsh, 2009). Bien (2009) presented evidence that those that are ranked highest on this measure

are also ranked highest on therapeutic outcomes. Mindfulness is thought to increase empathy with others by first developing it towards the self. As one learns to be gentle and non-judgmental towards the self, these skills seem to naturally transition to the manner in which we regard the world, including our clients (Bien, 2009).

Approaching clients and their situations with empathy is essential but not all that is necessary to achieve a positive therapeutic rapport. The ability to be a skillful listener is also central. As with empathy, mindfulness is thought to be an excellent mechanism by which to grow listening skills. Shafir (2010) described three key elements that are necessary for mindful listening, which are (1) the ability to sustain attention, hear and appreciate the entire message, (2) allowing a client to feel respected and valued, and (3) accounting for their own inner voice. These variables are quite self-explanatory and will be very familiar to any social work professional as they are reflected in the *Code of Ethics* (2005) that regulates our professional standards. Specifically, the first and third of these elements relate to competence in professional practice. A social worker must cultivate attuned listening to their clients in order to accurately understand their position, support their self-determination, and advocate as necessary (CASW, 2005). Equally important for competent social work practice is the ability to position oneself and understand how one's own values, experiences, and emotions might be affecting our appreciation of a client. The second element identified by Shafir (2010), respect and valuing clients, is directly related to the ethical requirement for social workers to respect the dignity and worth of all persons (CASW, 2005). Here, again, the overlap between elements central to mindfulness practice and the ethical underpinnings of social work supports the appropriateness for collaboration between mindfulness practice and social work. The fourth of the criteria described

by Shafir (2010) is intimately connected to the next element contributing to therapeutic rapport: self-awareness.

Self-awareness is the ability to understand our own 'filter' through which we receive messages. As mindfulness cultivates the ability to be present in, and aware of, the present moment, it can be immensely helpful for a social worker building their own self-awareness. Self-awareness is critical to sound social work practice, as it allows us to separate our own thoughts, biases, and experiences from those of our clients (Kessen, 2009). Beres (2009), in support of the discussion around mindfulness and self-awareness, added that mindfulness also helps social workers from allowing their own motivation to 'help' acting as a barrier to their work with their client. She highlights that our fixation on finding ways to help our clients can often contribute to us missing valuable information that they are sharing about their experience (Beres, 2009).

Finally, it is always essential that a social worker engage in building sound therapeutic relationships with their clients with acceptance and openness (Bien, 2009). Just as those who practice mindfulness are to be curious about the moment and able to 'be' in the moment without trying to change it, effective social workers are required to apply the same skills to their interaction with their clients. They are required to accept their clients as they are and to be open to their understanding of their situations (Wilson & Sandoz, 2010).

In concluding this discussion of the benefits of mindfulness to developing helping skillsets, a couple of cautions are equally imperative. While the potential benefits are plentiful, Pare, Richardson, and Tarragona (2009) provided a very important caution for those social workers wishing to use this mechanism to develop their skillset. They advised that when a clinician first implements mindfulness principles into their professional practice, there will initially be a diminished ability for that therapist to be present to their client (Pare et al., 2009).

This is because, as with learning any new skill, devoting mental energy to learning leaves cognitive resources less responsive (Pare et al., 2009). Further, it is also important to offer a caution that while skill level will develop and improve, the moment that a clinician allows themselves to believe that they have wholly understood their client – this is not empathy. Each of these factors is, and must remain, an on-going, continual process in order to remain aligned with the principles of mindfulness and with ethically sound social work practice (Walsh, 2009).

Mindfulness and Social Justice

Mindfulness has made an entry into a variety of helping professions over the past couple of decades. Professionals in the fields of psychology and of medicine are using mindfulness to improve the wellbeing of practitioners by reducing on the job stress and encouraging appropriate self-care (Shapiro & Carlson, 2009). As explained above, these same benefits are also being capitalized on in the social work field; however, social work also uses mindfulness to promote issues that are more unique to the discipline itself. Mindfulness can be used to enhance awareness of social justice issues both for clients and for social workers themselves. From a client perspective, being mindful can help them to understand their oppressive systems and disadvantages that impact their lives (Hick & Furlotte, 2009). This knowledge can be developed as their greater experience of awareness increases. A client who is more positioned in the moment is better able to observe and appreciate both their internal experiences (feelings, body tension, thoughts, etc.) and the external socially constructed forces (discrimination, oppression, stigmatization, etc.) that are impacting upon them. For social workers, integrating their mindfulness practice into their social work practice framework can enhance the experience of advocating for change. Rather than simply understanding oppression at an intellectual level,

social workers who incorporate mindfulness improve their overall awareness and/or experience of society's oppressive institutions (Hick & Furlotte, 2009).

As mindfulness requires the cultivation of awareness about the experiences of the mind and body, social workers who strive to increase their capacity for being present in the moment will be more able to notice oppression and discrimination while it is occurring (rather than simply having an intellectual understanding). With this increased capacity for awareness of oneself and of one's interaction with outside social forces, social workers can be empowered to minimize the ways in which they might inadvertently behave or think which contribute to oppressive societal structures or ways of being (Hick & Fulotte, 2009). Using mindfulness to promote awareness and change at a societal level (in addition to clinical practice) sets social work apart from other disciplines that tend to remain attentive only to the individual, clinical level of intervention without considering the broader societal opportunities for its application.

A Review of the Current Literature on the Impacts of Child Welfare Apprehension and Placement

Over the past 12 years of my career my observations about the manner in which child welfare workers execute the apprehension and placements of children have caused me increasing concern. My specific concern was that children who were removed from their parents and placed in alternate care were at risk of being traumatized by this process. However, I observed no awareness or attention to this potential impact in the manner that the apprehension and placement were undertaken or in the care provided to these children following this experience. I saw, in this system shortfall, the opportunity for the apprehension and placement of children to become considerably more trauma-informed, specifically through early interventions to trauma. These

personal observations and concerns prompted me to undertake a more formal and rigorous analysis of the current literature in order to assess my hypothesis.

My rationale was that with a thorough understanding of the current academic literature on the potential negative impacts of child welfare, I would be in a position to confirm and/or deny my concerns about the system and, consequently, to assess the ways in which my learning with early interventions to trauma might offer any potential benefits. The literature review presented below provides a summary and analysis of the potential indicators of trauma inflicted by the apprehension and placement of children. It also outlines the potential current opportunities for system improvement, and presents a consideration of the appropriateness of using early interventions to trauma as a tool in child welfare.

Approach to Research and Review of the Current Literature

Significant research has been amassed which demonstrates the deleterious effects of neglect and abuse on children. Children who suffer trauma and abuse have poor educational outcomes, decreased emotional well-being, an increase in physical health concerns, and potential neurological changes which result in delayed cognitive and social development (Anda et al., 2006; Bruskas, 2008; Ko et al., 2008). Once these impacts were recognized, society responded by establishing formal governmental agencies who were provided with the authority to intervene in, and work to, prevent cases of child abuse and neglect. When responding to the direst of situations, these child welfare agencies were endowed with the power to remove children from their parents and replace them in alternate care, effectively severing parents' physical and legal control over their children.

It is important to be mindful that with great power comes great responsibility. For child welfare practice to remain ethical and effective, it is critical any intervention be conducted in a

manner that does not focus exclusively on the harm that is being inflicted by the current circumstance. It is equally, if not more, important that the system act in a way which minimizes any potential negative consequences of this governmental intervention in order that both legislation and practice be aligned with these findings.

At the onset, a search was initiated for academic literature that specifically discussed the negative implications of the process of 'apprehension.' In child welfare terminology, an 'apprehension' is the process of removing a child from their parent or primary caregiver due to concerns for their safety or well-being as qualified in the *Child and Family Services Act* (CFSA)(2014). This search was administered through the Laurentian University Library via the Social Work Abstracts, Social Science Abstract, and PsycARTICLES databases. The search was limited to articles that were published in the past 10 years; however, in some cases, other older articles were included based on citations in the current literature. The initial search revealed no resources specific to the process of removal itself or the specific actions of child welfare or other professionals in this process. In the interest of thoroughness, a search was also conducted under GoogleScholar in order to verify that no academic materials had been missed. No additional articles were located via this method. In this search, one resource was found which was created as a training package (Center for Improvement of Child and Family Services Portland State University, School of Social Work, 2009). It has been included in this analysis due to its close relatedness to the subject matter and the legitimacy of the group that produced it. However, it does not appear to follow the rigors of regular academic research. The report obtained contains no reference or discussion of how the findings were gathered or analyzed.

After exhausting this primary search, new searches were undertaken which were broader in scope. This second round of search was directed at articles related to the negative implications

of child welfare more generally. Accordingly, searches were conducted on 'attachment theory', 'trauma-informed', and 'early-interventions', as they related to 'child welfare practice'. These search terms were used to illicit results that might help to provide a foundation for how the child welfare system might better serve children during the process of apprehension and placement. These results, while not extensive, did reveal sources that were pertinent. As a final attempt to extrapolate all relevant resources, additional sources were also drawn from the reference section of articles that were identified through the search techniques described above.

Apprehension and Placement in Child Welfare Practice: Reasons to Consider Trauma

To ensure a clear and coherent discussion regarding the potentially traumatic implications of apprehension and removal on children, these terms must first be defined. First, 'apprehension' in a child welfare context refers to the act of removing a child from their primary caregivers and residence. This process interferes with parental rights and control over their child and can only be authorized when a child's safety or well-being has been compromised or is at significant risk of being compromised (Government of Ontario, 2011). The process of placing a child occurs as a consequence of his or her removal, and it refers to a child welfare worker's decision about where that child will next reside while parents are addressing the alleged concerns. The *Child and Family Services Act CFSA* (2014) provides guidelines that direct who must be considered as potential caregivers and in which order of priority. An emphasis is placed on children remaining with relatives or community members and only when these options are inappropriate or non-existent will a child be placed in an approved foster or group care situation (Government of Ontario, 2011).

The concept of trauma does not have a succinct definition. Trauma is used both colloquially and in professional disciplines in a variety of ways. For the purpose of this

discussion, the definition of trauma that most closely relates to the childhood experience of trauma has been selected. The National Child Traumatic Stress Network (an organization funded by the United States Department of Health and Social Services, Duke University, and UCLA) defines a child's experience of trauma as falling into one of two categories, acute and chronic. Acute traumas are short-lived experiences which usually involve threatened or actual risk to life, personal safety, or personal physical integrity (National Child Traumatic Stress Network, n.d.). The second form of trauma defined is referred to as a chronic traumatic situation in which a child is continually exposed to a condition which leads to feelings of shame, fear and loss, and worry of personal security. Situations of domestic violence, emotional abuse, and physical abuse could be common examples of these chronic situations (National Child Traumatic Stress Network, n.d.). Both acute and chronic forms of childhood trauma are included, as they both will be relevant for child welfare involvement in different capacities.

With these important terms defined, attention will now turn to forming an argument and rationale for how and why it is important to consider the potential traumatic effects of being apprehended and placed by the child welfare system. The foundation of this argument is based on three primary areas. The first discusses the implications of these child welfare processes through the lens of attachment theory. The second outlines the characteristics of this client population and its inherent vulnerabilities. The third presents the risks and flaws inherent in the child welfare system. While each of these categories is addressed independently, it is important to acknowledge that they are all mutually influential and can serve to exacerbate one another.

Attachment Theory and Major Disruptions

Attachment theory was introduced by Bowlby (1988) who identified that a child's experience with their primary caregiver can be as influential in their development as their access

to other basic needs such as food and water (Bowlby, 1988). A child who reliably experiences a caregiver meeting his or her needs and helping them to return to a homeostatic state builds an affinity for that individual (Bowlby, 1988); homeostasis, in this case, refers to a state of satisfaction and comfort which may be physical and/or emotional. This allows them to develop a sense of predictability in their environment, and, later in life, a system on which they base their understanding and expectations about relationships (Bowlby, 1988). Both access to, and a relationship with, that caregiver remains critical (in coordination with their developmental growth) to a child until such time that they have the capacity to meet their own needs independently (Bowlby, 1988). Severing this relationship interferes with the child's sense of self-concept and their view of their world. Severing parental relationships is exactly what apprehension and placement forces a child to endure.

When these bonds are disrupted a child enters a place of increased vulnerability for relational, mental health, and developmental difficulties (Sammut, 2011). Apprehending children from biological families, even if there is legitimate, imminent risk to the child's safety or security, does not absolve the child welfare agency of their role in any potential consequences of that decision. Child welfare agencies must acknowledge that they have disrupted a child's access to their caregiver.

Critics of this position might argue that the disordered attachment relationships that can be common in conditions of abuse or neglect mitigate concerns about the removal. While there might be some merit to this criticism, it is also short-sighted. In most apprehensions, children are removed not only from their parents, but also from their communities, their schools, their extended families, and their siblings. The Ontario Association of Children's Aid Societies' (OACAS) *Your Children's Aid: Child Welfare Report 2009/10* indicated that in 2008-2009, only

5.8 % of all children-in-care were placed in Kin Care foster homes involving a person who had a prior, meaningful relationship with that child. Each of these relationships might have been with an individual who was acting as the primary attachment figure for that child (Mennan and O'Keefe, 2005). Groza, Maschmeir, Jamison, and Piccola (2003) and Heger (1993) highlighted that siblings are typically the most enduring relationship that people have and that these relationships can have important compensatory attachment implications for children who experience chaotic and inconsistent parenting. The realities of the foster care system are that children are often unable to be placed with their siblings due to system constraints. American statistics show that less than one third of children were placed with any of their siblings when they were removed from their parents (Shlonsky, Webster, & Needell, 2003).

These concerns are also compounded by the realities of placement instability in the foster care system. *Ontario Looking After Care (OnLAC) Reports* (2012) indicated that if a child is in foster care at age five, they can be expected to have had to change foster homes four times and that this number increases as children age (Commission to Promote Sustainable Child Welfare, 2012). Each of these homes marks another attachment disruption and another potential trauma or loss to that child. Furthermore, as Troutman (2011) astutely identified, there is also need to consider the complications to the primary goal of the child welfare system: reunification. Child welfare strives to return children to their families of origin and maintaining and/or rebuilding healthy attachment relationships with biological parents is a critical factor in this process. This goal is difficult to achieve due to the constraints of visit times and due to the initial parental difficulties that led to the removal. Children placed with healthy, trained, and financially stable foster parents can frequently form attachment relationships with their foster parents. This reality

can work at cross purposes with the goal of attachment and reunification to marginalized biological parents (Troutman, 2011).

Vulnerable Population

In addition to the potential harm caused by the child welfare system, children who enter the foster care system are already members of a vulnerable population. Children in this population have increased rates of mental health disorders, lower educational success, and they tend to live in poverty (Bruskas, 2008). The types of trauma that brings children into contact with the child welfare system (e.g., parental drug use, domestic violence, and emotional/physical/sexual abuse) are prone to occurring multiple times, being comorbid with one another, and being chronic in nature (Ko et al., 2008). Children's incomplete development compounds the potentially harmful impacts of these experiences because it can make it difficult for them to understand their experience and can be associated with self-blame (Balaban, 2006). The combination of the increased frequency of traumatic experiences and the lower capacity for coping (due to childhood developmental stages and marginalization) results in an increase in the level of clinically significant mental health impacts. Pecora et al., (2006) found that 21% of those leaving the foster care system had been formally diagnosed with Post-Traumatic Stress Disorder (PTSD), significantly higher than the 4.5 % found in the general population.

Risks in Substitute Care

Once children have endured the process of being removed from their parents, they are then placed in living situations that are approved of by the child welfare agency. Predominately, this is in family-based foster situations, although group homes are also relatively common particularly with older children and those with more intensive mental health or behavioural needs (Commission to Promote Sustainable Child Welfare, 2012). For some youth, the very interaction

with the system itself can result in triggering of past traumas (Conners-Burrow et al., 2013). Bruskas (2008), in her analysis, demonstrated in a number of ways, how involvement with the child welfare system is further marginalizing to children and can stigmatize and disempower them. Even more troubling is the fact that the risk and potential trauma of the child welfare system can expose children to new traumatic experiences due to multiple moves, and, at times, direct abuse or maltreatment while in-care.

Multiple-moves between foster homes (and group homes) can occur for a variety of reasons. At times, rather benign unpredictable factors can contribute to these moves such as a foster parents moving out of jurisdiction or a group home closing. However, many times the factors contributing to a move are much more concerning in and of themselves. For instance, sometimes the child's behaviour becomes unmanageable in a foster home. In some cases, children believe that if they act out enough they will be returned to their parents. Other times, their difficult behaviour can be related to disordered attachment, inability to function with rules and structure, or mental health conditions. These behaviours can be very difficult (sometimes impossible) to manage in a family environment. They can also interfere with or prevent relationships from forming with the care-providers which can increase the likelihood that these caregivers will ask for children to be removed. Finally, in the most disturbing of circumstances, children can be purposefully harmed by foster parents or caregivers. As with any occupation or volunteer position that offers intimate access to children, individuals with malicious intent can be attracted to fostering. At times, these intentions are solely for financial gain which can lead to neglect or emotional maltreatment. At other times, intentions are much more sinister and children are victimized by sexual or other forms of abuse. While every effort is made to prevent

these individuals with having access to foster or group care work, these measures are not fool-proof.

Minimizing Trauma in Apprehensions and Placement

In the section above**,** an argument was developed for why the removal and placement of children in the child welfare system ought to be considered for the potentially traumatic effects it might inflict. The primary benefit of this process of assessing the child welfare system is that it serves to identify which factors might be critical to remediation and improvement. Three opportunities for improvements in the system through better attending to trauma are presented below.

Prevention of Child Welfare Involvement

The opportunity to prevent harm in child welfare can occur at a number of different levels. The most succinct way to address potential trauma caused by interaction with the child welfare system is to prevent entirely that interaction. Child welfare involvement should never be the first social service agency to provide support to a family. The majority of issues related to the protection and well-being of children have underlying societal causes which can better be addressed by collaboration between social services which are less stigmatized, intrusive, and disruptive. It is critical that this philosophy of minimal intrusion be maintained once child welfare involvement has been initiated. Apprehension and placement of children should only be used in the most critical cases where children are at risk of immediate or significant harm and where there are no appropriate methods to make them safe in their own family and /or home environment. Mennan and O'Keefe (2005) highlighted that consideration of the dire impact of severing attachment relationships can help workers to better weigh the risks presented. In this regard, it is a more holistic approach by recognizing the potential costs and weaknesses that

coming into the care of the child welfare system may cause, rather than simply weighing the parents' struggles in isolation.

Adopting a strengths-based perspective is a credible asset to social workers who wish to consider the full abilities that parents have to offer to their children. Strengths-based social work offers to child welfare workers a framework and practice perspective that will encourage these preventative strategies. Strengths-based social work seeks to improve the lives of clients by mobilizing their strengths and assets rather than focusing on their deficits (Sabalauskas, Ortolani, & McCall, 2014). Taking this perspective should encourage child welfare workers to keep child protection concerns as a factor in their holistic assessment of their client and his/her family. It should also encourage the worker to remain mindful of some of the detriments that the system itself can impose.

Opportunities to allow for the inclusion of the potential impacts of being apprehended in determining case decisions would need to be integrated at both the system and the worker level. At a system or organizational level, this would make child welfare agencies more accountable in two regards. First, this should motivate Children's Aid Societies to integrate a more significant level of creativity to keep children at home where possible Perhaps this might involve practical in-home support for parents to provide hands-on education about parenting, maintaining a safe home or one-to-one support for behaviourally challenged children. The approval of funding for such preventative options should be weighed against both the financial costs of caring for children in the foster/group home systems (daily per diem, clothing, transportation, sports/activities, assessments, counseling etc.) and the potential harm that might be unintentionally inflicted by introducing a child into the child welfare system.

Second, it should also promote child welfare organizations to offer the strongest, most well-resourced foster care system possible. It is both illogical and unethical to justify removing children from their parents based on inadequate or harmful parenting techniques if a higher standard of care is not going to be offered. From a worker perspective, the duty would be to remain mindful of these potential risks of in-care parenting in their analysis of case planning and advocacy for services and supports.

Trauma-Informed Child Welfare Practice

In general terms, trauma-informed child welfare practice means that both the professionals and the policies demonstrate an understanding and acknowledgment of the concept of trauma. Specifically a trauma-informed child welfare system would recognize the historical traumas of families and children, potential triggers, and how engagement with the system and professionals might aggravate prior traumas and/or cause new harm (Conners-Burrow et al., 2013). The intention of practicing with this awareness is to support clients in effectively resolving post-traumatic difficulties, and even more importantly, to prevent the infliction of new traumas (Conners-Burrow et al., 2013).

The majority of child welfare clients have suffered some form of trauma, in fact, traumatic experiences such as physical/sexual/emotional abuse, neglect, and domestic violence are the very factors that illicit their involvement in the system (Conradi, Wherry, & Kisiel, 2010). For this reason, child welfare workers need to have considerable expertise about trauma and how to engage effectively with traumatized clients. The process of this literature review uncovered only one comprehensive training program that attempted to address the ways in which child welfare employees and other service providers can reduce the trauma of apprehension and placement of children; the National Child Traumatic Stress Network (NCTSN).

The National Child Traumatic Stress Network (NCTSN) developed a toolkit and training curriculum that was used in each of the articles that focused on issues of trauma-informed service delivery in child welfare (Center for Improvement of Child and Family Services Portland State University School of Social Work, 2009; Conners-Burrow et al., 2013; Ko et al., 2008). The NCTSN's toolkit was used in a range of capacities in these studies. Both the Child and Family Services Portland State University School of Social Work (2009) and Ko et al. (2008) used the guidance of the toolkit to develop training suggestions for first responders of a variety of professional disciplines (including child welfare workers, foster parents, medical examiners, and police) each of whom commonly engage in the process of a child welfare investigation. In both studies, the potential impact of trauma caused in the process of apprehension and placement was analyzed in the context of the specific stage of engagement and according to the particular role played in an attempt to identify ways to minimize harm (Center for Improvement of Child and Family Services Portland State University School of Social Work, 2009; Ko et al., 2008). Conners-Burrow et al. (2013) used the information in a more structured, formal analysis to show that the fairly modest training program (maximum three day training program) was able to cultivate improved awareness and understanding of trauma and its implication amongst child welfare employees in a variety of roles.

To provide a fair and comprehensive assessment of this NCTSN program it is also important to acknowledge areas of deficit. The most blatant deficit is that there is no indication of direct involvement of clients in the research reviewed. The information was collected exclusively from the perspectives of the professionals and collaterals involved. These were their observations, and to some degree, speculations on the experiences of clients and what might improve the process. While it might be difficult (or even unethical) to interview children who are

currently in-care or have recently endured being apprehended from their parents, interviews with previous Crown Wards who have aged out of the child welfare system might provide an ideal source of input in order to include a client perspective.

Overall, the research that I reviewed demonstrated a number of overarching areas of deficit in the current process of apprehension and placement. First, the child welfare system and workers need to become more sensitive to identifying trauma in clients (Ko et al., 2008). Further to this issue, child welfare workers also need to have an in-depth knowledge about how trauma directly affects their client's behaviours and emotional presentations (Conradi et al., 2010).

Fortunately, early indicators seem to demonstrate that efforts to provide this training to child welfare workers had a positive and lasting effect and that those with the least formal education benefitted the most. Specifically, those workers who had college degrees reported greater learning and impact on their work with clients than did those with university and graduate level degrees (Conradi et al., 2010). This would support the argument in support of the potential benefits in extending this training to those who support children-in-care in a less professional capacity. For instance, foster parents might be ideal candidates for the training. They are highly motivated to provide support to children and also have the greatest amount of time with children in care, particularly immediately following an apprehension. While child welfare workers' expectations are divided amongst a variety of different responsibilities including coordinating all the professionals involved, supporting parents, and completing court requirements, foster parents' sole focus is to provide support and care to the child.

While hands-on training at the frontline is an absolutely critical factor in improving trauma-aware service delivery, it is equally important to ensure that the legislation, policies, and procedures that guide child welfare practice are aligned with this approach. The Ministry of

Community and Social Services in Ontario is responsible for monitoring individual child welfare agencies' application of the *Family and Children's Services Act (CFSA)* (2014). The *CFSA* (2014) places both obligations and constraints on how children and families are to be protected. It is here that child welfare agencies find the authority for both the apprehension and placement of children. While the *CFSA* (2014) outlines the role of child welfare agencies, it does not provide direction on how these goals will be achieved. This more direct instruction is determined by each individual agency in their policy and procedure. From this agency-centre position, responsibilities are then assigned to individual front-line workers in their job descriptions. At each of these levels, there is an opportunity to support and encourage the use of trauma-informed practice.

The research in this field identifies concrete ways in which trauma-informed practice might be more formally integrated into each level. At the Ministerial level, the opportunity exists to emphasize guiding principles which are deemed to be critical. For instance, over the past decade, there has been an increased focus on the obligation to place children with kin (Government of Ontario, 2011). This has led to an increased burden to demonstrate that kin have been actively sought out as opposed to just allowing the opportunity to respond. Previously, child welfare workers would simply indicate in court that parents could not identify any family members who might be able to put forth a plan and that was considered sufficient. Now, child welfare agencies must demonstrate that they have proactively sought out potential kin or community members by following family records, contacting cultural and/or religious groups, and speaking directly with parents and other immediate and extended family members (Government of Ontario, 2011). Similar expectations could be placed on individual agencies to demonstrate that their engagement with their clients was done from a trauma-informed

perspective in order to minimize harm. Individual agencies are held accountable to these standards on a more immediate basis through the Family Court system and on a more comprehensive level through yearly Ministry audits of case files.

The policy and procedures of individual child welfare agencies offers another opportunity for those agencies to make a concrete commitment to clients that the role previous traumas have on engagement with child welfare services is appreciated and that prioritization of this awareness will be reflected accordingly. As identified in the above discussion, it was found that formal training programs delivered to child welfare workers were successful in improving their awareness and understanding of trauma (Conradi et al., 2010). Such training programs could be made mandatory for all workers and be defined in policy and procedural manuals. Additionally, commitments could also be made to incorporate practice tools which most reliably and effectively gather information from clients on their history of trauma. Conradi et al. (2010) astutely identified that information on trauma is already being gathered from clients in an informal way as a part of intake and other investigative interviewing processes (Conradi et al., 2010). They suggested that the information ought to be gathered by a tool that has been tested for reliability and validity and can gather the greatest quality of data (Conradi et al., 2010). The researchers specifically propose the benefits of a transactional model for trauma assessment designed by Spaccarelli (1994). Spaccarelli's (1994) model identified and accounted for the fact that the client's potential trauma history cannot be considered in isolation. It supported the importance of this information, stipulated that there are also likely elements of the investigative process that might lead to development of trauma symptomology, and suggested that these also need to be accounted for (Spaccarelli, 1994). Authorization of universal tools for all child

welfare workers performing investigative and assessment duties offers the unique opportunity to both encourage consistency in assessment and individualization of service.

With regard to consistency in assessment, requiring the use of formal assessment tools can ensure that a worker has a full appreciation of the trauma that the client has endured as specific questions will ensure that conversations are initiated and that they are guided in a systematic way. Formalizing the requirement of such assessments would help to minimize differences in capacity amongst child welfare workers, as all clients would be offered the same opportunities to share information (opposed to relying on the awareness of the professional to ask the appropriate questions). With regard to individualization of service, it is impossible to build an individualized service or intervention plan without knowledge about that client. Formalizing the collection of trauma history, triggers, and areas of sensitivity can set a foundation of information to guide these plans. As an example, for some clients, service plans might include provisions for transportation to attendance at domestic violence counseling. This information could also help to guide the manner in which workers interact with their clients. For a client who has had her children apprehended from her home, meetings might be conducted in the child welfare office or in another neutral location that offers confidentiality. Once again, integrating an obligation into policy and procedures provides clients with an opportunity to hold both the agency and their individual worker to that standard. Internally, it also provides a standard of expectation for the agency and employees to remain committed to use to direct their practice.

Early Interventions and Potential Child Welfare Implications

Opportunities to improve trauma-informed knowledge and practice in Ontario's child welfare system were outlined above. Early Intervention (EI) is a set of interventions that are

specially tailored to be delivered in the aftermath of a traumatic event or experience. The primary intention is to act in a manner to prevent the negative psychological implications of trauma and minimize the likelihood of an individual developing post-traumatic stress disorder or another diagnostic level stress injury (Dyregrov & Regel, 2012).

As established above, child welfare apprehension and placement can present significant risk to the emotional well-being of children; however, they can also have the rather unique characteristic of being a 'planned' trauma. The *CFSA* (2014) legislation encourages child welfare workers to approach their work in a planned and systematic way and to involve the family court system at the early possible juncture, ideally prior to the apprehension. In addition to following legal checks and balances, the planning and preparatory stages of an apprehension are also critical to minimizing trauma (Center for Improvement of Child and Family Services Portland State University School of Social Work, 2009). Unfortunately, there are circumstances in child welfare in which children must be removed from their homes and families in an emergency-driven manner that does not afford such organization. However, in both the planned and unplanned circumstances, the trauma occurs under the guidance of a trained social worker. This provides the opportunity to intervene differently than in other traumatic situations where professional supports are not available with the support of EI methods creating the potential for prevention (or at least minimization) of trauma.

Early interventions, when properly implemented, should be 'psychological first aid'. They are intended to address the immediate physical and psychological needs from an integrative approach which acknowledging how the body and mind process trauma in concert with one another. Importantly, they are also intended to be client-driven and individualized (Devilly, Gist, and Cotton, 2006; Dyregov and Rebel, 2012). They might involve physical exercises or

disruption of memory consolidation (Dyregov and Rebel, 2012). As related to the process of apprehension and placement, EIs might provide useful guidance and information for a variety of those adults acting in a supportive role in the process of apprehension and placement. A full exploration of the ways in which EIs might be integrated into these processes is beyond the scope of my current analysis because the purpose is simply to establish their appropriateness in a more general sense. However, a couple of examples will help to illustrate and explore the feasibility of this goal.

During the process of the apprehension, diversionary techniques might be used in order to minimize the child's memory of the apprehension. Dyregrov and Regel (2012) discussed instances where the use of video games has helped to disrupt memory formation has mitigated the impact of the trauma. Once placed, this approach might also help foster parents to better understand and support children to settle into their home in a manner that will mitigate the magnitude of the trauma. For instance, it is common for children to be unable to sleep upon placement in foster home on the first evening after their apprehension. It is a common human caregiving instinct to ease a child to sleep in order that he or she is able to recover from the emotional turmoil that he or she has been through. In seeming contradiction to this instinct, an EI perspective that would suggest allowing a child to remain awake might minimize the full integration of their memory of the traumatic event. This, in turn, may decrease the likelihood of Post-Traumatic Stress Disorder and other diagnoses. Once again, this is not intended to be a full exploration of the potential uses of EI in apprehension and placement, but rather as an illustration of some of the possible implications and benefits. Further study would absolutely be necessary in order to assess for appropriateness in a systematic manner. A more detailed consideration of these issues is provided in the fourth and final chapter of this thesis.

Conclusion

In conclusion, in this chapter I have provided the findings of the most current and relevant literature pertaining to victims of crime and early interventions to trauma, mindfulness and social work practice, and a review of the current literature on the potential impacts of apprehending and placing children in out of home care. Collectively, these reviews have formed the foundation for my experiential learning during my practicum placement with the Victim Crisis Unit with the Ottawa Police Service. In the following chapter, I will provide a more detailed description of my practicum placement and the learning goals that pursued while engaged in that learning environment.

Chapter Two

Description of Advanced Practicum

As I detailed in the introduction to my thesis, two of my primary intents in undertaking this thesis were to become proficient in understanding and implementing early interventions to trauma and to improve my overall capacity as trauma clinician. I determined that my best opportunity to achieve this goal was through experiential learning in a practicum environment where I could benefit from both observational and direct-practice learning environments with those actively engaged in the field. In this chapter, I will provide detailed description of the Ottawa Police Service's Victim Crisis Unit and its function within the broader community and victims' services domain. I will also introduce a more detailed explanation of my practicum learning goals.

The Practicum Environment: Victim Crisis Unit at Ottawa Police Services

The Victim Crisis Unit (VCU) is a distinct section within the Ottawa Police Service. It is composed of a unique combination of sworn members of the police force and civilian employees. The civilian staff members are trained professional crisis counselors who typically hold a background in social work or counseling psychology. Beyond collaborative work internally, the VCU also maintains strong formal and informal networks within the community at large. It is integrated into the network of social service supports for those recovering from victimization and trauma, and is well represented at community boards and initiatives (Ottawa Police Service, 2010).

The VCU specializes in providing supportive counseling and other services to members of the public who experience trauma as a result of a tragedy in which police are involved (e.g., workplace accident or suicide) or being a victim of crime. The VCU offers professional needs

and risk assessments to their clients in order that an individualized support and action plan can be developed. The mission for its internal professional crisis counselors is to offer respectful and compassionate crisis and post-trauma counseling, as well as advocacy and education in navigating the criminal justice system. Collaboration within the Ottawa Police Service (OPS) (between sworn officers and VCU) and between VCU and external service providers is critical to VCU members being able to afford the best care to clients. When the needs of clients extend longer-term, VCU professionals coordinate referrals and connections between victims and other community based social service agencies in order to provide the best continuum of care to its clients (Ottawa Police Service, 2010).

The Victim Crisis Unit counselors are assigned clients by two primary means: via a computer-based work cue, and via an emergency response request for on-scene support. All incidents and criminal occurrences are coded via an alphanumerical system when they are entered into the Ottawa Police Service data base. Those codes that are related to the VCU mandate are assigned to a work cue and dispersed amongst team members by the Team Lead. The victims or witnesses in these circumstances tend to be involved in less serious offences or circumstances that do not require immediate support. Other referrals are made directly from on-scene police officers. These requests occur in circumstances where those affected would benefit from immediate intervention and support to ensure their psychological safety and wellbeing. Involving VCU workers in these situations allows victims and/or witnesses to be assessed by an appropriate professional in order to determine follow up supports. It also allows police officers to be freed to focus on the elements of the event which are more predominately related to law enforcement. While the method by which VCU workers become involved varies from the point

of intervention, the supports and services offered are dictated by that client's individualized needs.

As is true of many service agencies, broader societal trends and economic forces have impacted (and continue to impact) the Victim Crisis Unit. The main trends currently demonstrated in the victims' services industry more generally were presented in the first chapter of this thesis. Next, I have considered these trends as they presented with the VCU specifically.

Evolution of Victims Services and Multisystem Service Delivery

I would argue that the very existence of Victim Crisis Unit is an example of one of the primary developments of the victims of crime movement. As introduced in the literature review, the interests of victims of crime have become much more central in both the criminal justice system and the social service field (McBrearty, 2011; Williams, 1999). Law enforcement agencies have traditionally been offender-focused systems. Their sole interest in victims was determined by their usefulness as a tool of 'evidence' to ensure the conviction of offenders and historically, financial resources were allotted to these priorities.

The development and funding of a department whose exclusive purpose is recognizing and addressing the potential pain and suffering of victims is an interesting development in the face of current economic reality. The OPS has been determined to be the third most understaffed police organization in the country and is further facing a 2.5 million dollar budget cut for 2015 (Canadian Association of Policing Governance, 2014; Ottawa Police Service, 2013). It is unclear at this point in time whether the development of victim services programs (such as VCU) within law enforcement agencies is representative of an evolution from a traditional, offender-driven system to one that is more holistic and inclusive in its approach to policing or whether its existence will be threatened given these resource constraints.

A related finding presented in the literature review on victims of crime was the growing tendency for service providers to interact and to be required to provide service in a collaborative manner. It was identified that due to this trend in service delivery, complications commonly occurred as a result of misunderstanding and miscommunication about roles and responsibilities between different service agencies and professionals which led to victims being overlooked or poorly serviced as a result (Cooper et al., 2008; Ljungwald & Svensson, 2007; McBrearty, 2011).

At the onset of my placement, I anticipated that having VCU incorporated within the police service would greatly minimize these weaknesses. My belief was that law enforcement and VCU social workers would have a more intimate understanding of one another's roles and responsibilities due to their close collaborative work. I also believed that the police officers' awareness of the availability of victim's services might be increased due to being located internally within the police station. Furthermore, I anticipated that having VCU workers as employees of the Ottawa Police Service would provide them with an even higher level of credibility and validity in the eyes of these same law enforcement professionals. As my placement progressed I recognized that the situation remained much more complex. There were a variety of interacting systems, both internally and externally, which reflected the very complexities that were identified in the literature.

First and foremost, the Ottawa Police Service remains a policing agency. Social work purposes are respected but are a secondary function and must be practiced within the limits of the policing context. The VCU interventions are provided to clients who are often actively involved in an on-going criminal investigation or court process. This might be as witnesses or victims. In either case, they can play a pivotal role to the outcome of criminal convictions and the integrity

of the case. There was often a complex balance between the need to meet client needs without compromising evidence or testimony that the client may have to present. These concerns were particularly relevant in the interactions between VCU and some of the specialized investigative units due to variations in legal charging requirements. For instance, the criminal justice system manages sexual assault differently depending on the relationship between assailant and victim. In Canada, there are mandatory charging requirements for law enforcement officials when there is a violent or sexual crime committed between two people who once had, or are currently in, an intimate relationship (Ontario Ministry of the Solicitor General, 2000). In contrast, victims who are assaulted either sexually or physically by a stranger have the opportunity to refuse to press charges (Ontario Ministry of the Solicitor General, 2000). This legal distinction adds another layer of complication to providing services to clients who have not yet given their evidence or testimony. Victims have been known to no longer wish to pursue criminal charges if they have received service and support. While ensuring the well-being of that individual client is the sole interest of the VCU worker, the police function from a position of broader societal goals including public safety. If a victim no longer wishes to participate in a criminal process, it can compromise the ability to accomplish those broader societal responsibilities.

The Victim Crisis Unit typically reconciled these conflicts in interest by focusing first and foremost on the safety of the client, opposed to any processing of the details or long-range impact of the crime or trauma. As indicated above, risk and needs assessments were conducted with the client and used to help them formulate a safety plan. These also helped to highlight informal and formal supports and resources that might already be in the individual's network. Finally, this also allowed for presentation of other resources available that might be desirable for

the client over the longer term to delve into these more sustained needs. This approach also respects the VCU mandate, which limits their work to emergency-response, short-term service.

Complications in providing quality social work in a multi-system service delivery were not only internal. There were also issues of 'jurisdiction' that were complicated based on community protocols and mandates as well. The interaction with hospital social work departments was a prime example of these complicated service delivery rules and regulations. There is considerable overlap in client population between potential VCU clients and the hospital social work system. Many of the circumstances such as fatal car accidents, suicide attempts, or acts of domestic violence that might make individuals clients of the Ottawa Police (and therefore clients of the VCU) also brings them into contact with the health care system. Once a client has contact with a hospital, any social work services required become the domain of the hospital social worker. While this is an issue of mandate, there are some areas which make it considerably more complicated and could easily lead to the gaps in services identified in the literature review (Cooper et al., 2008; Ljungwald & Svensson, 2007; McBrearty, 2011). The hospital social worker might be unavailable at a specific time of day or there might not be a social worker available at a specific hospital. Therefore, they become eligible for support from VCU counselors.

The risk for a service gap here is that there were so many opportunities for failure. There was no systematic way to identify whether or not the client might be without hospital social work services. The navigation of this system seemed to be entirely dependent on the knowledge and experience of the particular police officer assigned to that matter. If the officer's attention was demanded by the on-going criminal aspects of the case, then there was an even greater possibility that a gap in service might occur for the victim or witness. While it might seem reasonable to

allow the client to select the service that they found a better fit, the priority appeared to be more driven by the service providers 'entitlement' to provide service and their desire to maintain control. As an outsider, I also questioned whether or not, in some circumstances, there might be more specific expertise to be offered by the VCU social workers. Hospital social workers have a variety of social work responsibilities in their role, ranging from discharge planning, to family support, to mental health assessment. VCU workers are much more narrowly focused and provide only short-term trauma focused social work which should reasonably leave them in a more experienced position to provide service to this subset of clients. At the base level, this is a similar dynamic to the deference that occurred internally within OPS where law enforcement goals and principles were prioritized over services to victims. Rather than internal, this hospital/VCU circumstance is an example of the prioritization of broader systemic interests over the interests of the individual client at the community level. This situation occurs when service providers become preoccupied with their 'right' to provide service over the client's benefit of having the most skilled expert available.

Agreement with the Organization and Supervision

The Victim Crisis Unit has a well-established history offering Master's level students the opportunity to gain valuable learning experiences through hands-on practice within this specialized sector. I was required to submit a written application to be considered for the formal interview process. I was then interviewed by two current members of the VCU team for approximately an hour and a half. The purpose of this process was two-fold. First, it ensured that any applicant had the capacity to do trauma work in a clinically sound and ethical manner. Second, it was also intended to ensure that the applicant was prepared for the potential emotional toll of the work.

During my practicum placement, I received clinical supervision and direction in two primary ways. First, I received direct clinical supervision and direction in service with clients. At the onset, I worked primarily with Ms. Eva Savage who was the member of VCU tasked with the responsibility of supervising a student. I began with participating in interventions in a purely observational role, moved to joint interventions, and finally managed sole interventions. I also had the opportunity to shadow each of the other team members as our familiarity with one another grew. I was truly impressed by the openness and support that each clinician offered me. This allowed me to benefit from learning from a variety of professional philosophies and backgrounds. The second form of supervision that I was offered were structured sessions. In order to satisfy the supervision criteria outlined in the Laurentian University MSW Student Handbook (2010), I had formal supervision meetings every three weeks with a member of the team who held an MSW, Ms. Traci Bowen. Ms. Bowen was also available on a daily basis to provide support and encourage my learning and consulted regularly with all of the members of the team to gain feedback on my performance. In the final few weeks of my practicum, I also participated in a group supervision, which included my first reader, Dr. Diana Coholic, Ms. Traci Bowen, and myself. This phone conference provided the opportunity for discussion on the progress of my placement. I was exceptionally fortunate to have had a truly inspirational and fulfilling learning opportunity.

Practicum Goals

Embarking on this practicum, I defined three main goals. The first two goals centered on improving my professional social work skillset and my capacity to provide effective ethically sound trauma intervention. The first goal I defined was to develop my knowledge of, and ability to use, EI to trauma techniques in order to deliver individualized psychological first aid during

traumatic crisis or immediately thereafter. Relatedly, my second goal was to improve my capacity as a trauma clinician by developing my awareness and understanding of mindfulness and its usefulness in preventative self-care and as a tool to improve therapeutic engagement between client and clinician. Finally, in the interest of fully integrating my learning and professional experience, I planned and completed a critical analysis of the potential implications for early interventions for child welfare practice.

Below, I have explored each of these goals in greater detail. I have also composed and attached a table (see Appendix A) to detail the specific, measurable objectives that I undertook to achieve these learning goals. To do so, I created a framework of learning objectives which were specific and measurable. Tasks, supports and resources, achievement indicators and timelines were assigned to each learning objective. This chart was created primarily as a tool for my own learning, but it has been included to provide insight into my learning process.

Early Interventions to Trauma

As I discussed in my introduction, to this point in my career I have had the luxury of primarily long-term, case management-based work as a context in which to practice. This practicum provided me the opportunity to address my personal skill deficits at the 'front end' of the continuum of trauma care. In preparation for this learning, I conducted a thorough literature review on EI to trauma and victims of crime. The extensive results of this process are presented in the first chapter of this thesis; however, they were very influential in the learning plan that I developed. I was particularly impacted by the level of debate about the efficacy of EI to trauma and the potential for clinicians to inflict harm on clients should these techniques not be fully understood and applied according to best practice principles.

In order to attend to this potential risk of harm, the objectives that I defined related to EI to trauma had a heavy emphasis on becoming familiar with the VCU protocols, job description, and training. I also paid particular attention to the observational phase of my placement in order that I could benefit from seeing the interventions 'in-practice' before attempting to implement them on my own.

Trauma Intervention, Mindfulness Practice, and Social Work

I selected mindfulness practice as an important method of improving my social work skills and my own preventative self- care. Mindfulness practice has been found to offer benefits related to presence and acceptance which can play a considerable role in managing stressful and demanding situations which may contribute to vicarious trauma (Napoli & Bonifas, 2011). As established by Hill (2013) in the literature review, the emotional tolls of the type of work performed by VCU clinicians were significant. These same benefits associated with mindfulness practice (presence, empathy, listening) were also found to have positive impacts on a social worker's engagement with clients, which is a critical factor in successful client outcomes (Bereceli & Napoli, 2007; Beres, 2009; Bien, 2009; Gehart & McCollum, 2010; George, 2009; Kessen, 2009; Napoli & Bonifas, 2011; Shafir, 2010). Thus, these objectives related to mindfulness were also equally important in order to maintain my capacity for learning and my ability to contribute professionally to VCU clientele.

Critical Analysis and Child Welfare Applications

As my time with the VCU was limited to a 450-hour placement, I was cognizant of the importance of formally integrating this learning experience into my daily social work practice in child welfare. For this reason, I used my research and experiential learning to set the foundation for a critical analysis of the potential for EI with trauma to better inform child welfare practice. I

have used the combination of the research that I introduced in my literature reviews (both the literature review of EI and that on the trauma of child welfare interventions) and my experiential learning from my practicum to evaluate how the traumatic effects of apprehending children might be mitigated. The results of this undertaking are presented in the final chapter of this thesis. Having now described the learning environment and my learning goals, the following chapter will present a detailed account of my practicum experience.

Chapter Three

Growing Capacity as a Trauma Clinician

Two of my primary learning goals related directly to my active participation in my placement and the knowledge that I hoped to gain through this opportunity. These goals were to gain the ability to understand and implement early interventions to trauma and to develop my overall capacity as a trauma clinician. Below, I will present the most memorable responsibilities and duties that I undertook in my role as a VCU clinician and my reflections on how they relate to these learning goals.

Observing Social Work Practice

It has been my experience over the past 12 years working in child welfare that there are rarely opportunities for an employee to be in a pure 'learning role' that is protected from the demands of the job and is specifically focused on improving the skill set of the social worker himself or herself. While there are few opportunities for training and career development upon entry to the field of social work, these can dissipate even further as one becomes more experienced. The opportunity to shadow OPS Victim Crisis Counselors provided for me the very rare opportunity to observe high-level social work intervention without having the responsibility to provide service to clients.

A social worker's role while engaging with clients is extremely complex and demanding. For instance, in my work as a child protection worker, a multitude of simultaneous responsibilities are required such as active engagement with the client, assessing for safety, developing hypotheses, and formulating questions. Fulfilling these responsibilities is extremely taxing and consumes intellectual resources. I find that my ability to reflect on the skills and interventions that I am employing is compromised by my devotion to the client's needs at that

time. While in a learning position as an advanced practicum student, I was able to observe the process of intervention, the intersection of different professionals, and the interactions amongst these systems and the clients themselves without having to be concerned about the level of support and service being provided to clients being compromised.

While a number of learning experiences were facilitated by being in this 'student' role, I found one of the most powerful and impactful examples was the ebb and flow of the processing of grief or trauma. Both the family (and/or victims), as well as the professionals, routinely moved into periods of 'reprieve' where jokes were told, laughs had, moments of calm and stillness and a strange 'normalcy.' I believe these periods to serve similar, but not identical, purposes. VCU support was often called 'on-scene' due to loss of life in an unforeseen and tragic manner, such as suicide, overdose or traffic accidents. From my perspective, for family members these periods of reprieve (as described above) appeared to be part of a need to recover from the draining, emotional experience that they were enduring. They also appeared to be part of the process necessary to process the reality of the incident. The times when clients were more 'present' and engaged allowed opportunities for them to interact with the professionals, while the moments of deeper emotion required the professionals to offer a balance of remaining available, yet non-disruptive to the family's need to have privacy with one another.

For the professionals, the ebb and flow between active engagement in their work and more socialization-driven interactions appeared to be a tool used to create some distance from the human suffering. Avoiding becoming too overly involved in the emotional and/or caretaking elements of the crime scene or trauma was particularly important for those who needed to remain the most objective and analytical. Detectives and front-line police officers have significant responsibilities for determining the etiology of events and maintaining the integrity of the scene.

It would be reasonable to assert that the ability to manage these tasks would be compromised by becoming overcome by one's own personal emotional reactions and experiences. For all professionals (coroners, VCU, police officers, paramedics), there is also the reality that their exposure to trauma is increased exponentially by virtue of their jobs.

This observation impacted my personal practice in two significant ways. First, the victims and/or family members' emotional and behavioural reactions during these circumstances pushed me to develop my capacity for self-awareness and my ability to adjust the intensity of my presence to suit the clients' needs and the circumstance. The learning opportunities that I was provided with, particularly on-scene, occurred during intensely painful, personal moments in clients' lives. As I was in a learning role, it was necessary that I not negatively interfere or impact their opportunity to receive service. Observing was a unique privilege to improve my learning and skillset; however, it had to be done in a manner that did not make clients feel 'under a microscope'. I became partially attuned to my physical placement in a space, my ethic/cultural background, and my gender. The second significant area of impact that this 'on-scene' experience allowed was a recognition and appreciation for the skill set necessary to remain both appropriately present, yet not become overly personally impacted. I will reflect more thoroughly on this aspect in a later section of my report, as it related directly to my implementation of mindfulness practice as it pertains to self-care.

Formal Training Opportunities

Beyond the natural/observation based learning experiences, I was also afforded the opportunity to attend formal OPS training program on both violent risk threat assessment and mental health.

OPS sponsored a training program offered by Threat Management Inc. on a range of violence threat assessment tools offered. This was a two-day training opportunity provided to specialized divisions of the OPS including VCU, Sexual Assault and Child Abuse (SACA) and Partner Assault. Representation was also present from the Crown Attorney's Office. The training focused on four specialized, evidence-based tools for assessing a variety of types of violent threat that fall in the domain of criminal justice partners: Brief Spousal Assault for Evaluation of Risk (B-SAFER), Stalking Assessment and Management (SAM), Historical Clinical Risk-Management-20^{V3} (HCR-20^{V3}), and the Assessment of Risk for Honour Based Violence (PATRIARCH).

The primary focus of the training was the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). The B-SAFER is a tool used to assess the risk of intimate partner violence which is defined as "the actual, attempted, or threatened physical harm of a current or former intimate partner" (Kropp, Hart, & Belfrage, 2010, p. 1). This assessment tool was developed by Kropp, Hart, & Belfrage (2010) to replace the Spousal Assault Risk Assessment (SARA). The SARA which had been in use for many years is a more cumbersome tool which requires significant expertise about mental illness to achieve an accurate assessment (Kroop, Hart, Belfrage, 2010). The B-SAFER is a standardized tool which is intended for use in a multi-disciplinary setting with a strong focus on information gathering. While the B-SAFER accounts for the risk factors of the offender, it also balances the equation with the strengths and assets of victim (Kropp, Hart, Belfrage, 2010). The victim is not a passive recipient of the offender's decisions. They are rather the most important asset in their own protection and empowerment. The inclusion of the victim's network of supports and personal assets is particularly important in

light of Sims et al.'s (2006) findings that it is the single most important indicator of their recovery from a traumatic experience.

As it name implies, the SAM is used to assess the risk related to stalking behaviours. Stalking is defined by this tool as "unwanted and repeated communication, contact, or other conduct that deliberately or recklessly causes people to experience reasonable fear or concern for their safety or the safety of others known to them" (Kropp, Hart, & Lyon, 2008, p. 1). This tool was often used in conjunction with the B-SAFER in cases of intimate partner violence, particularly if the couple had separated.

The HCR-20^{V3} is the most general violent threat assessment tool that was included in the training. It is used to assess an individual's propensity for interpersonal violence against other people, outside of an intimate relationship. Potential victims may or may not be known to the perpetrator (Douglas, Hart, Webster, & Belfrage, 2013). This tool would commonly be used in situations to determine the need to incarcerate or release criminal offenders or in the education system to determine the risk level a student might present.

The PATRIARCH differs somewhat from the other tools because it is specifically designed to assess the risk associated by a variety of specific cultural, moral, and/or religious ideology and can be used with a client of either gender. It specifically assesses the level of risk of actual or potential violence that is motivated by belief about 'honour' (Kropp, Belfrage, & Hart, 2013). Honour-based violence is driven by ideology that tends to be shared in a family or community, and therefore, there can be multiple potential perpetrators that present risk to one individual. Most commonly the violence is triggered by sexual behavior that is deemed unacceptable or shameful. While it is commonly thought to be exacted upon women, men who

violate social rules and norms can also fall victim to this form of violence (Kropp, Belfrage, & Hart, 2013).

Each of these tools shares some promising commonalities. First, each acknowledged the potential 'victim's' resources and skillset. The 'victim' is seen as the expert in sharing information about their circumstances. This can be a particularly important opportunity for advocates and social service providers to work collaboratively to promote self-reliance and empowerment. Clients who have been marginalized by oppression based on their gender or culture may have had little opportunity for self-determination. Placing them in a position of authority over sharing information with service providers can be an opportunity for empowerment in order to help clients to re-capture their 'voice' through exploring and gaining understanding of their unique individual experience, as well as the more systemic obstructions that have been inflicted on them (Lee & Hudson, 2011). Ideologically, this approach is also highly compatible with a strengths-based approach to social work, which also makes them appealing for my own personal perspective as a social worker.

Second, they all emphasized the need for collaboration amongst service providers. Great value is assigned to the information gathering phase which requires the involvement of a number of professionals, not solely those involved in the criminal justice system. It has already been presented that the literature indicates a general trend toward multisystem service delivery in the victims' services sector. It was also presented that the current state of this multisystem service is fraught with service gaps and role confusion (Cooper et al., 2008; Ljungwald & Svensson, 2007; McBrearty, 2011). It is possible that the integration and development of these structured, collaborative tools is a promising indicator about the future of multisystem victims' services. Providing formal, standardized, and evidence-based tools can provide a common language

amongst professionals from different fields of expertise (law enforcement, court system, social work, medical professionals, etc.) that might help to mitigate some of the misunderstanding and service gaps identified. Third, each of these tools relies on structured professional judgment (SPJ). Structured professional judgment is a hybrid approach to decision making combining unstructured clinical judgment and actuarial approaches. The intent is to capitalize on the benefits of both approaches while minimizing downfalls. SPJ sets guidelines for how information should be gathered and considered without being fully prescribed (Kropp, Hart, & Belfrage, 2010). The guidelines are based on the current academic literature and designed to ensure best practice. This form of decision-making bolsters the accuracy and comprehensiveness of these tools by making use of literature and professional expertise, while minimizing subjectiveness.

Although I was not able to complete training in mental health awareness, I thought it important to acknowledge that the OPS also offered the opportunity to participate in mental health awareness training. The training was offered jointly by Dr. Peter Boyles of the Royal Ottawa Hospital and Detective Quesnel of the OPS, Mental Health Unit. The course was intended to provide an increased awareness and knowledge-base to frontline officers who often respond to mental health calls. With better education, it was thought that there could be a more appropriate determination between those clients who were having a mental health emergency which required medical intervention and those who were displaying ‘typical’ symptoms of their chronic mental health difficulties and might be more traumatized and further stigmatized by involvement with police (Boyles & Quesnel, 2014). I cannot speak to the entire content of the training as, unfortunately, it was disrupted on the first day by the shooting that occurred at the War Memorial and the need to employee all officers to secure safety. Given the information now

known about the shooter and his extensive mental health history, it would seem that such training opportunities for law enforcement officers are exceptionally important. The primary relevance that I identified in this training was its existence. I would argue that this training is an indication of the OPS's growing commitment to de-criminalizing mental health. Educated and informed officers who are aware of appropriate resources are much more likely to use them. This training also placed a priority on personalizing mental health and empowering those who experience it on a daily basis. The entire second day of the training was devoted to Dr. Boyle's patients who had both positive and negative experiences with law enforcement due to their mental illnesses.

Direct Interventions with Clients

Without question, the most powerful impact of this practicum was the privilege to engage with clients of the VCU. As introduced previously, clients can obtain service from VCU via either workflow queue referrals or 'on-scene' response. While the services available to clientele are unaffected by the path by which they become involved, their implementation by the crisis counselor can be significantly different. On-scene services are emergency-driven. The traumatic or criminal event has only just occurred and the police investigation is being initiated. The single, greatest priority at this stage of the intervention is safety. This includes both the client's safety and well-being immediately after, and in the period following, the event. Immediate physical safety has typically been established by law enforcement; however, even the stability of this basic level of safety can change dramatically once officers have left the scene. Emotional well-being can also be exceptionally tenuous during these times. Under these circumstances, the crisis counselor's role was an intricate balance of providing information and support when necessary, and retreating into the background when the clients were meeting their own needs either independently or with their informal support systems such as family and friends.

In contrast, for clients who are referred via the workflow queue, the counselor benefits from a considerable degree of control over the circumstances of the intervention. The opportunity exists to review all of the pertinent police reports. A time and location can be scheduled which are most comfortable for the client and conducive to their fullest involvement in their own intervention. Preparation and familiarization can also be done proactively so that materials and referrals to other services are able to be presented to the client in a timely manner. After a period of shadowing and joint-interventions with both on-scene and follow-up cases, my practicum supervisors, Ms. Eva Savage and Ms. Traci Bowen, determined that I was prepared to schedule and engage with clients on my own. This provided me with the opportunity to solidify the learning that I had done through observation and to consolidate these skills. Through both the 'observational' phase of my placement and the more autonomous portion, a pattern of common direct invention techniques began to emerge which are presented and discussed in further detail below.

Risk and Needs Assessment and Safety Planning

One of the greatest, concrete skills that I gained from my practicum experience was the ability to produce a thorough, complete, and accurate risk and needs assessment for trauma. Risk and needs assessments were used in every case scenario; however, they were always individualized to the situation and to the client. The risk and needs assessments were even used in a systematic fashion on the day of the War Memorial shooting. Over one-hundred witnesses and victims were triaged by the VCU team and by volunteers from the local hospitals' mental health team. As I was responsible for amalgamating and inputting the majority of the clinical notes, I was able to make some observations on the nature of the interventions as a whole.

It was immediately apparent that the quality and quantity of the information included in the assessments varied considerably. In some cases, critical factors such as history of previous trauma, immediate presentation after the incident, and access to formal/informal supports were missing. I found it most interesting to note that the 'gaps' in information were identifiable between those clinicians who were part of the VCU team and those who were not. The assessments completed by the VCU team members were more detailed and more comprehensive. I do not intend this observation to be a judgment of skill or professionalism and hypothesize that there were two potential reasons for this difference. First, it is likely a difference of experience and specialization in trauma and catastrophic events. This particular VCU team also supported Ottawa residents through the OC Transpo bus accident that occurred in Barrhaven, Ontario on September 18, 2013. This tragic collision involved dozens of victims and resulted in the death of six of the bus' occupants. Survivors witnessed extreme carnage and human suffering. The chaos that followed left family members struggling for hours to determine the health and welfare of loved ones on the bus. The magnitude of this event provided a preparatory experience for the VCU team in providing service at large-scale incidents.

Second, I also believe that the professional discipline of those involved might also have contributed. The mental health team workers were all nurses who work under a medical model of care. The VCU team is composed predominately of social workers along with other social service work professions. The quality and quantity of the risk and needs assessments were also notable as they contrasted with normal VCU case notes. For a considerable period of time, VCU workers were instructed to be quite brief and succinct in the notes that they created for client files. This instruction was particularly interesting given the policing environment. Police officers reports were extremely detailed and lengthy. As I finished my placement, new formal guidelines

and templates for client case notes were being developed. These were intended to capture much more of the clinician's impressions and professional insight opposed to simply their direct observations.

Once risk and needs assessments were completed, they were used to inform safety plans. Safety plans were concrete actions plans that were targeted at ensuring the client's physical and emotional well-being. They were individualized to the client's needs with some focusing extensively on protection from outside risk factors such as ex-partners. Interestingly, while these might include exceptionally practical and hands-on planning with regard to varying travel routes and routines, practicing emergency 911 calls, and increasing situational awareness, it was typically the overall sense of self-reliance and 'feeling' of safety that was most impactful for the client. Planning for safety was another area that had some parallel experience in my work in child welfare. However, safety planning with VCU was much more in-depth and extensive, and it is a skill that I now hold a much greater degree of expertise in with my return to child welfare.

Knowledge of Resources and Referrals

It seems perhaps overly simplistic to spend time discussing the knowledge that I gained about resources available in the community and how they can be accessed. I have included it for two reasons. First and foremost, I have included it because it made a powerful difference to the quality of service that I was able to provide to my clients. This was particularly true as I began to work independently with clients because I could no longer rely on the knowledge of the professional VCU worker. I have also included this learning experience because it was an area of weakness upon my arrival to VCU. As I shared, I have only previously worked professionally in Renfrew County and in child welfare. My experience with the OPS was a new community and a new service agency with an entirely new group of clients. There was a considerable learning

curve, as I needed to become familiar with an entirely new area of governmental and non-governmental services. My ability to advocate and engage for my clients required that I do so.

The Client Population: Victims of Crime

My first-hand experience with VCU supported many of the realities presented about 'who' the characteristics of the clientele served by VCU would be. Amstadter et al. (2007) identified two particular characteristics that differentiated victims of crime as a population from those who had endured other traumas. These authors found that victims of crime were more likely to have been subjected to previous traumas, and they had an increased likelihood of experiencing future trauma. Although, I was not able to evaluate the accuracy of this comparison between groups in a purely scientific manner, after only a few short weeks, I observed this to be a fair and accurate characterization of the victims that I encountered.

Realizing the validity of this statement was most impactful for me because of the importance that it placed on connecting with victims of crime. While the actual crime might have a fairly minimal impact on that individual's life, the contact with VCU acted as an opportunity to engage with clients and identify other potential unresolved and debilitating trauma. VCU intervention was serving a 'screening' function that helped identify unsupported clients in the broader population and created an entry point for service delivery. This was particularly important as many clients were marginalized individuals who may not have otherwise have had awareness or access to the resources available in their community.

I believe that this broader 'screening' function should be considered as additional evidence of the legitimacy and benefit of VCU services. Based both on the current research findings and my own observations, being victimized by crime marks an opportunity to engage and offer valuable, life-altering services. Hill (2013) strongly argued that it is critical not to

conclude that these general facts about victims of crime will be true of all individuals. Just as most victims of crime will have the personal resources to cope with their experience without the need for outside intervention, there will also be victims of crime who do not share this history of prior trauma. As is central to the EI research, the services offered to a client must always be client-driven and individualized.

The other major finding from the review of the literature on victims of crime that I found worthy of critically consideration was the concept of the 'perfect victim.' As discussed earlier, Cooper, Anaf, and Bowden (2008) and Ljungwald and Svensson (2007), have suggested that a bias exists toward de-legitimizing the worthiness of victims who played some contributory role in their own victimization (e.g., the victimization occurred in the midst of a criminal act) and that this results in diminished service from both law enforcement officials and from social workers. From my direct observations, the majority of the clients that were served under the VCU mandate were the 'less-than-worthy victims' that Cooper et al. (2008) and Ljungwald and Svensson (2007) described in that most played at least some contributory role in their own victimization. Most victims that were supported during my time with VCU had significant mental health problems, had significant criminal histories, and/or were victimized while engaging in a related criminal act. However, rather than reflecting a highly aggressive, antagonistic population, this reality seemed to be connected to the fact that they had also had significant histories of previous trauma. Many of the clients lead high-risk lifestyles where it is often simply a matter of when, not if, they will be harmed. They were at higher risk to themselves (mental health, medical issues, addiction, etc.) and from others due to their marginalization (physical assault, sexual assault, emotional abuse). Each trauma served to

increase the likelihood of another occurring (Green, 2007; Ljungwald & Svensson, 2007; McBrearty, 2011, Sims et al., 2006).

The prejudice and stigmatization articulated by Cooper et al. (2008) about such victims was also present in clear and concrete ways, perhaps most blatantly with regard to access to funds. The Ministry of the Attorney General finances a program called the Victim Quick Response Program (VQRP). This offers a variety of types of support for those victimized by a violent crime that occurred in Ontario (Ministry of the Attorney General, 2014). The eligibility criteria for VQRP specifically articulate that anyone who faces charges related to the incident is ineligible for support (Ministry of the Attorney General, 2014). It is not necessary that a victim be convicted of the offence alleged against them to be denied access to these services, simply being charged was sufficient. This criminal charge might only be related to the criminal incident that resulted in their injury or loss. These prejudicial eligibility criteria mean that victims who are beaten, sexually assaulted, or robbed can be denied counseling, can be unable to have biohazards cleaned up from their homes if it is the crime scene, and are unable to secure funds to have their locks repaired or changed. I witnessed a number of the dire implications of such eligibility criteria. One particularly poignant example was the situation of a woman who was a drug addict and prostitute who was viciously assaulted by a friend in her own home. The woman was involved in an altercation related to illicit drugs. As the assault occurred related to a crime, the client was unable to secure funding to clean up the significant amount of blood and tissue that was left in her home.

Practice with Special Populations and Circumstances

The Victim Crisis Unit also provides support to a number of special populations within their broader client base. Three that were particularly impactful for me were interventions related

to honour-based violence, domestic violence, and large-scale incidents of trauma/victimization. I will present each of these areas as they impacted my knowledge and ability to practice.

Honour-based violence

I live in a homogenous population of white, English speaking, native born Canadians in rural Ontario. I recognized, prior to beginning my placement with VCU and acknowledged in my preparatory objectives (see Appendix A), that practicing in Ottawa, a culturally diverse, urban population would be an opportunity to stretch my social work skills. The client population of VCU was also ethnically and culturally diverse which offered the opportunity to practice with tools such as a language interpreter. There was a disproportionate representation of women who were recent immigrants and/or refugees from countries of predominately Muslim faith. These women tended to come from families that were extremely traditional and/or devout and who were recent immigrants to Canada. What was particularly shocking from their stories to me was the blatant incidents of physical threat, intimidation, and violence that they suffered since their arrival in Canada.

As a White, Canadian-born, English speaking woman, I at times felt a sense of insecurity and unease with regard to how to navigate these incidents of honour-based violence. As they are associated with a particular minority religion and/or culture, I was concerned about how to reconcile my reaction to the practices with my own majority-culture values and privileges. With the support of one of my placement advisors, Eva Savage, I was able to reconcile my discomfort by conceptualizing these acts as an issue of human rights instead of religious or cultural freedom. Cultural freedom and expression should be limited at the point at which it impedes upon another individual's human rights. From this perspective, my judgments were guided by a respect for my client's human rights, rather than a condemnation of cultural or religious practices.

Notwithstanding the need to continue to test and reconcile my cultural awareness and sensitivity, I was equally surprised by the times where I was able to connect with clients with relative ease across these barriers of language, culture, and race. It was impactful for me as a female social worker to appreciate the connectedness that is perhaps easier fostered between women and the unique ability to appreciate the oppression that had been inflicted on them.

Parallels are often drawn between honour-based violence and domestic violence along with assertions that the approach to intervention can be similar. I would hypothesize that this comparison is made as both forms of violence are most commonly perpetrated against women. With scrutiny there are considerable differences which are worthy of consideration and exploration. As they relate to intervention and support, the primary difference was related to the dynamics of perpetrators and supports. In a situation of domestic violence, there is most commonly one perpetrator – the current or ex-intimate partner. In situations of honour-based violence, entire family and community groups can present risk. Both male and female members of the family can be responsible for guarding the family's honour. This can also be true of entire communities of ethnic or religious populations. When an individual breaks the cultural traditions that are prescribed, they can be reprimanded by a variety of different sources. The situation of honour-based violence is additionally differentiated from domestic violence by the fact that, in cases of domestic violence, the woman's family is typically her greatest support.

Due to these exceptional complexities, I only worked in joint interventions with full VCU counselors with clients who sought support for honour-based violence. This joint-intervention process provided a greater learning experience, as I had the opportunity to process and de-brief with highly-skilled workers after interventions.

Domestic Violence

Victims of domestic violence are common in the child welfare system. The approach to intervention from a Victim Crisis Counselor role provided me with significant learning opportunity. I found intervening with victims of domestic violence the most stressful of all client groups because of the on-going element of risk that is associated with intimate partner violence and stalking. Many of the VCU clients had endured an isolated incident of trauma or victimization, for instance a traffic accident or an act of violence by a stranger. In these situations, the incident itself is past, and as a practitioner, I only had to concern myself with supporting the client in their recovery. Victims of intimate partner violence present with an on-going threat of violence and risk of re-traumatization or even death. From my perception, the level of risk was exasperated by the court system's very poor appreciation for the level of terror and risk that abusive partners present. It appeared as though they were repeatedly arrested only to be released hours later. There were rarely mandatory educational programs for offenders and the cases can exist in the court system for years.

Earlier, I discussed my opportunity to learn the B-SAFER and SAM tools. I think that these would have been a great asset in my ability to feel satisfied that my client and I had accurately assessed their level of risk and thoroughly examined their personal supports. Unfortunately, the training occurred over the last few days of my practicum placement, so I did not have the opportunity to practice them first-hand with clients.

Large-Scale Incidents

One of the most unique learning opportunities that I experienced during my practicum placement was also the most tragic: The War Memorial Shooting. On October 22, 2014, a gunman shot and killed Mr. Nathan Cirillo, an unarmed Honour Guard, at the National War

Memorial. The shooting was managed as an act of terror and emergency services procedures were enacted. For the Ottawa Police Service, this included the calling to duty of every sworn officer available and the mobilization of the entire team of VCU crisis counselors. Police stations across the city were placed in lock down, and the VCU unit was called to the downtown police station located only blocks from the shooting.

From my observations, what was particularly notable were the similarities to individual traumas. The experience of those impacted by the shooting was much what I had observed during interventions with much more personal traumas and victimizations. The majority of those impacted had the personal resources and supports necessary to manage without intervention or interference from professionals. While the scale was greatly expanded, the approach to intervention by VCU workers was also strikingly similar. All victims and witnesses were attended to individually and offered both an immediate opportunity for service or for follow up the following day. As I discussed in detail in my discussion of risk and needs assessment, the needs and risk assessments were also implemented with over 100 witnesses. While the structure of the individual sessions during the War Memorial shooting were similar to interventions with victims in more common individual crimes and/or traumas, the coordination of information, follow-up, and services was extensive. This aspect of the service delivery was equally critical to client care, but it was an aspect of social work provision that I had not previously been involved with or responsible for.

The other interesting difference that I noted when comparing this with other interventions was that I was also a ‘participant’ in the event in a manner that was different from other interventions. At the onset of the shooting, little was understood about the scenario that was developing. The incident was initially believed to be an international terror threat; therefore,

emergency protocols were initiated. These were particularly vigilant in the OPS stations where we were housed as VCU workers. All stations were placed in a state of 'lock-down' and emergency response preparedness. As a team, we travelled into the downtown core where the head police station is located which is in close enough proximity to the event that victims and witnesses were able to walk to receive support. While I never felt my personal safety was directly threatened, it was most definitely a new experience to be in an active professional role where there is an on-going large-scale threat to the safety and security of an entire community.

The Victim Crisis Unit Team

I have spent the past 12 years, my entire social work career, working at Family and Children's Services in Renfrew County. While I have worked in different positions (which required some degree of re- training) transitioning into the VCU team required that I develop an understanding of an entirely new agency, new team, and new job requirements. Doing so diligently was a necessity both to work in a safe and ethical manner. Through the process of preparing for this transition and in the process of acclimatizing to the new position, I noted one particularly interesting difference between functioning of the VCU team and the team dynamics that I experienced in child welfare. In contrast to child welfare, the VCU professionals practiced an informed awareness and appreciation of the potential risks for secondary trauma amongst co-workers.

VCU and child welfare responsibilities both require significant work with clients who have had traumatic experiences. Working with these clients and in these circumstances can expose workers to experiences that are difficult to appreciate by those who do not work in the same field. As Hill (2013) documented, elevated levels of anxiety, anger, and frustration are common amongst those who work with victims of crime. Kessen (2009) demonstrated that these

emotional experiences can create the risk of secondary trauma and burnout for social workers, particularly those who serve traumatized client populations.

My experience in my regular employment has been that one of the most common methods that workers use to cope is to discuss their experiences with other social workers. On the surface, this seems like a reasonable, if not positive, coping mechanism; however, my work with the VCU team caused me to re-consider this position entirely. At the onset of my placement, I reasoned that 'venting' to co-workers was reasonable for a number of reasons. Other child welfare professionals are bound by confidentiality and can provide meaningful input in case management decisions. They also have a unique ability to appreciate the nature of the work and the effect of the demands on the social worker him or herself. However, the professionals at VCU had a significantly different awareness of the potential downfalls of this practice; they were much more cognizant of the fact that the increased exposure brought on by discussion amongst co-workers might compound risk of vicarious trauma. VCU team members were keenly aware of limiting their own exposure to disturbing images and information and not contributing to the exposure of their teammates. Vivid descriptions and discussions of case material can be difficult enough. When this extends to written or visual materials, the results can be even more impactful. VCU members are perhaps more cognizant of the risk of vicarious trauma due to the extremely graphic, sensory nature of some of their on-scene work such as traffic accidents or suicide scenes. However, photos and verbal accounts of child abuse and horrific living conditions would also likely present with a degree of risk.

I found being sensitized to the potential risk that I might pose to my colleagues by implementing these coping strategies profound. It is something that I am keenly aware of now since I have returned to work. Fortunately, I have also been able to off-set some of the need for

this form of coping through my own individual mindfulness practice which I will discuss at a later point in this chapter.

Reflecting on Early Interventions to Trauma

One of my three primary learning goals and a skill that I saw as central to the 'success' of my social work practicum was gaining a fuller understanding of techniques of early intervention (EI) to trauma. I anticipated that these would be highly prescribed, structured social work tools. In reality, I found EI to trauma was much more a philosophy of practice for VCU than a specific set of interventions. The VCU practices in a manner that is practically and ethically consistent with the literature review findings on EI to trauma. These approaches were individually translated according to the specific counselor employing them and the client with whom they were engaging. Perhaps most interestingly was my realization that many of the learning experiences that I described above were in fact highly correlated with the findings laid out in the literature review.

Briefly summarized, there were five major characteristics of ethically sound and effective EI to trauma outlined in the literature review. Each of these was represented and respected by execution of VCU work with clients. First, it was clearly identified that Early Interventions to trauma were not therapy, but rather short-term, emergency-based psychological first aid (Devilly et al., 2006). Respect for this is represented in the very mandate of the VCU team which outlines that VCU workers will serve to assess and ensure safety and connect clients with appropriate, longer-term services in the community as necessary (Ottawa Police Service, 2010). Second, comprehensive risk and needs assessments that reach beyond the current trauma were considered a central component (McNally, Bryant, & Ehlers, 2003). This aligns both with my observation that each intervention, regardless of scenario began with a risk/needs assessment and even more

pointedly it aligns with the observation when contrasting the risk and needs assessments completed from the War Memorial shooting. Rather than an ideological or skill-level difference, it would seem reasonable to suggest that the variation actually reflects a clinical understanding and compatibility for the principles of proper EI to trauma. Third, the literature further prescribes that safety is the primary goal of any intervention with a recently traumatized client (Devilly et al., 2006; Dyregov & Rebel, 2012). A focus on safety and security was a clear priority both in terms of practical and emotional well-being (Devilly et al., 2006). As I have previously detailed, this was evident in the prioritization of comprehensive risk and needs assessment and the resulting safety planning. Fourth, individual interventions were also cited as critical both in relation to personalization and with regard to the ratio of client to clinician (Dyregov & Rebel, 2012). Interventions performed by VCU staff were almost exclusively done on an individual basis, with the exception of presence of the client's chosen support person. They were always client-led and highly attentive to support the client in identifying and mobilizing their own unique assets and support systems. Finally, a psycho-educational component appropriate to the client and circumstance was also deemed to be important (Roberts & Everly, 2006; Phipps, Byrne, & Deane, 2007). I observed attention to this component in three aspects of the work completed by the Victim Crisis Workers. Information and education was provided regularly regarding both the criminal justice system and its functioning and with regard to resources available in the community. Also, normalization of general symptomology that might be experienced was discussed.

The literature review on EI to trauma presented in the first chapter of this thesis identified two primary areas of debate; ethics/efficacy, and timing. Many criticisms lobbed at EI to trauma argued that any intervention this early on after a trauma was counterproductive because it

contributed to rather than supported the trauma. However, with further clarification and analysis it became clear that helpful EI to trauma were possible and could be distinguished from their potentially harmful counterparts by a number of defining components namely, psychological first aid, risk and needs assessment, safety planning, psychoeducation, and individualization. These characteristics are critically necessary for best practice with EI to trauma because they minimize risk of harm caused by the intervention itself. The learning experiences that I have reviewed above highlight the consistency that the VCU approach maintains with these same five principle elements of EI to trauma, which combine to achieve best practice.

The remaining area of debate relates to the timing of the intervention. As indicated, some of the variation of opinion on appropriateness of early interventions to trauma centered on exactly what 'early' meant. The issue of timing is interesting to consider given the two primary ways in which interventions are conducted by VCU. On-scene interventions, by definition, occur during or immediately following the trauma or criminal event, while those assigned via the workflow queue may have occurred days earlier. The need for extra vigilance when intervening with recently traumatized clients due to their vulnerable emotional and physical state was identified across researchers (Devilly et al., 2006; Dyregov & Rebel, 2012; Elhers & Clark, 2003; Gray & Litz, 2005). Research by both Elhers and Clark (2003), and Gray and Litz (2005) spoke specifically to the consistency between the presentation of PTSD symptomology immediately after a traumatic event and the later formal diagnosis of the disorder. This would seem to provide additional support for the benefits of the professional on-scene observations and intervention of VCU workers as they are determined by individual clients. It also provides support for the need to triage efficiently through workflow assignments in order to initiate offering of service in as timely a manner as possible. VCU's 24 hour a day, seven day a week

staffing would appear to indicate a pre-existing respect for the power of timing. However, as Hill (2013) reiterated, exposure to a traumatic or criminal event and the development of any diagnostic level PSTD or anxiety symptomology is not absolute. The majority of individuals will recuperate from their experience without any need of outside intervention. In fact, intervening where unnecessary can be counter-productive, as it can be disruptive to natural coping supports and methods (Hill, 2013). The importance for early access to clients is for assessment and determination of treatment opposed to a universal approach to intervention.

Overall, it would appear that not only are the principles of ethically sound, effective early intervention to trauma well-respected by the Victim Crisis Unit, but that it is actually an ideal framework for many of the requirements and/or constraints of providing social work services in a policing environment overall. That it is short-term, safety-focused, and is not therapy decreases the likelihood of interference with the criminal justice agenda.

Implementation of Mindfulness as a Social Work Clinician

As introduced in the first chapter of this thesis, mindfulness has made a recent but growing introduction into the field of social work. Mindfulness can serve to inform the field of social work in a number of different capacities. For the purpose of this practicum, my introduction into mindfulness practice served two primary purposes, specifically as a means for improving therapeutic rapport, and for preventative self-care.

Mindfulness and Social Work Skill Set

The literature review on mindfulness and social work identified that many of the skills that are developed by mindfulness practice are central to proficient social work (Beres, 2009; Hick, 2010; Lysack, 2010). Many of these skills are central to developing a strong, therapeutic relationship. The therapeutic relationship was found to be the single most important factor in

determining client outcome (Hick, 2010; George, 2009; Lambert & Simon, 2010). Therefore, the ability to cultivate its capacity is invaluable to any social work practitioner. Below I have discussed how the benefits of mindfulness practice were specifically valuable in the context of my VCU placement.

To this point in time, my career in the social work field has primarily been based in long-term working relationships with clients. This has afforded me the time to build trust and rapport in a more natural, gradual manner, and by consequence, a strong therapeutic relationship with clients. The nature of crisis intervention work is challenging in that it requires that a therapeutic relationship be developed in less than optimal circumstances both due to the nature of the events they have recently (or are currently) occurring and the short-duration of the relationship that is dictated by EIs to trauma. In fact, the relationship is so short – ranging from one to three sessions – that disengagement typically begins by the end of the first appointment. This was a considerable new challenge. I found each of the four ways in which mindfulness can contribute to therapeutic rapport, important in developing this capacity.

First, mindfulness practice was identified as offering the opportunity to contribute to empathy (Bien, 2009; Lambert & Simon, 2010; Walsh, 2010). Personally, I found that feelings of empathy for clients were quite easy to access, perhaps due to their current circumstances. Many of these clients had just endured an incredible tragedy or loss which I found naturally triggered feelings of empathy for me. Skillful or mindful listening identified by Shafir (2010) as critical to therapeutic rapport was particularly challenged by the dynamics of on-scene VCU work. The scenes and situations that I attended with the Victim Crisis Unit clinicians were often chaotic, noisy, and over-whelming. There were multiple teams of professionals seeking to complete different goals all of which required the attention of the client in some capacity.

Maintaining presence in this scenario and connectedness with the client was quite challenging particularly given that I was also experiencing a steep learning curve with regard to intervening at a crime scene.

Both Beres (2009) and Kessen (2009) added that cultivating mindfulness was also beneficial to a social worker's ability to remain self-aware, which was also essential to therapeutic relationship between client and worker. I used mindfulness as a regular reminder to 'check in' with myself and the views that I was formulating. This was a particularly active process for me during interventions that were especially graphic or challenging to my personal values and beliefs. On-scene interventions for suicides or overdoses tend to be more sensory. The visual images can be shocking as can the smells. These occurrences also involve more medical personnel such as the coroner and those responsible for body removal. I regularly tried to acknowledge and experience any feelings of discomfort, intruding thoughts, or anxiety that I experienced during these situations in order to try to minimize their interference with my interactions with clients. These feelings of anxiety and discomfort were strong for me at times due to my inexperience in the circumstance and my desire not to be counter-productive to the family's grieving process. Essentially, I felt as though my process of self-awareness presented as acknowledging and giving permission for my personal emotional reactions while trying to ensure that they did not negatively impact my connection with the client.

Curiously, particularly during these tragic on-scene interventions, there is a 'disconnect' between the compulsion to take action because an emergency has just occurred and the realization that there is nothing that can be done. The circumstances become very process-driven after such an event and there is the need to be prepared for a multitude of different reactions in these circumstances. The ability to be open and accept these sometimes 'awkward' or shocking

displays of grief and trauma was one of the primary ways in which the need to practice 'acceptance' presented itself. Interestingly, although considerable research focused on how mindfulness could be beneficial to developing engagement with clients, none of the research attended to the process of disengagement. The short-term nature of EI work required that the process of disengaging from clients begin almost simultaneously with the engagement process because it would be unethical and unhelpful for a client to develop an overly connected bond when the entirety of the therapeutic relationship would last no more than three sessions at most. Admittedly, given the intensely intimate nature of the information being shared and the current vulnerability of the client, the ability to manage the disengagement required much more conscious and purposeful effort.

Professional Self-Care and Personal Practice

More profound than the role that mindfulness offered with regard to social work practice skills was the impact that it offered for my own personal self-care and growth. Even in contemplation of this practicum I recognized that I would need to practice considerable self-care in order to remain healthy and balanced while exposed to the level of trauma and tragedy that would be involved in taking on trauma-based social work. I was hopeful that developing my own mindfulness practice would act in a preventative manner and help to insulate me from the risk of vicarious trauma.

Developing a mindfulness practice was not something that I found naturally inclined to. It took both discipline and effort, particularly in the beginning. I began by taking 10 minutes on a daily basis to focus on a specific activity or sometimes a specific sense. It was necessary in the beginning that I carved out specific time to 'practice' or else my days were over without even

considering mindfulness. I found that taking the time to journal my experiences even when they were frustrating helped to re-solidify my commitment.

I found the transition from practicing mindfulness as an 'activity' itself to transitioning to being more mindful throughout the day the greatest challenge. Toward the end of my placement I found that mindfulness became much more of a way of 'being' versus a conscious effort or thought process. Even though I began my practice with the explicit intention of using it for this practicum, I've found that it has carried much more broadly into other aspects of my life. I am much more present in my relationship with others in my personal life and much more conscious of my internal emotional state.

The difficulty with preventative interventions is that it can be impossible to ascertain their efficacy when one remains healthy. I left my placement with VCU without experiencing any negative repercussions from being exposed to traumatic occurrences and situations. It is possible that I would never have been vulnerable to the effects of vicarious trauma. Just as many people, if not most people, have endured traumatic experiences and have had sufficient personal resources to avoid any long-term negative impact on their emotional well-being, this is equally true for those who have worked providing trauma services (Hill, 2013). Regardless of whether or not mindfulness practice insulated me from vicarious trauma, the overall benefits that it provided to my well-being made my practice worthwhile for me.

Institutional Attention to Health and Wellness at the Ottawa Police Service

While I was exposed to many incidents of trauma during my practicum placement, the War Memorial shooting was the most major incident. It also differed from other experiences as there was some degree of an on-going level of perceived threat directed at law enforcement in the initial period following the shooting. As a VCU placement student working alongside law

enforcement professionals, we, as a team, were also implicated in this perceived threat. Response to the increased level of physical threat was immediately addressed by the sworn members of the OPS. Attention to my mental health and wellbeing was addressed at the more direct level of VCU, both by collaterals and by management. I was immediately offered the option to be as minimally or fully involved in the VCU initiative on this day as I wished. It was my personal choice to continue on with the team due to the intense learning experience that it offered. Attention was also paid to physical needs throughout the day long intervention. Food and water was supplied as was opportunity to take breaks from the intervention process. At the end of the day, there was also an opportunity to receive support from other team members if that was desired. Ultimately, I experienced no negative impact from my involvement in this tragedy. In fact, I found the opportunity to participate and contribute professionally invigorating.

Conclusion

This third chapter represents the compilation of my most impactful and rewarding learning experiences during my practicum placement with the Victim's Crisis Unit. While these opportunities were meaningful at the time when they were experienced, the act of reflecting and processing them in this document served as another chance to consolidate learning. Turning to the fourth chapter, a critical analysis of the potential applications and implications of early interventions to trauma for the child welfare system (particularly the processes of apprehension and placement) are presented. This chapter represents a reflection on the whole of my practicum learning and an attempt to integrate this new knowledge into my professional work for the benefit of clients.

Chapter Four

Child Welfare and Appropriateness of Early Interventions to Trauma

In the first chapter of this thesis, an exploration of the potential trauma caused by involvement in the child welfare system, and some of the potential opportunities to reduce this negative impact, were presented in a literature review. Based on my analysis of the literature I proposed the consideration of early interventions to trauma as a framework to inform the manner in which the apprehension and placement of children is carried out. The purpose of this fourth chapter is to present my reflections and considerations of this discussion having now completed my practicum placement working with the Victim Crisis Unit where I observed and used early interventions to trauma on a daily basis. I will first present an argument in favour of the appropriateness of drawing comparisons between the two practice contexts. After establishing that foundation, I will present a reconsideration of how EI to trauma might remediate some of the current gaps in child welfare practice. Finally, I will conclude the chapter with a more specific consideration of EI techniques as they could be integrated into the process of an apprehension and placement.

Contextual Compatibility: Comparison across Mandate, Client Populations, and Practice Environments

When the intent of this practicum was developed, it was proposed solely based on the findings of the literature reviewed. Below, a re-consideration of the appropriateness of the comparison has been presented that is now informed by both the literature and my practicum learning experience. The two practice contexts were compared across their mandates, client populations, and practice environments in pursuit of this goal.

Mandate

Both child welfare agencies and the Victim Crisis Unit are professionally sanctioned assessors of risk. This primary purpose is reflected in both of their mandates. At the highest level, child welfare in Ontario is guided by the *Child and Family Services Act* (*CFSA)* (2014) which bestows on child welfare agencies the duty to protect and maintain the well-being and safety of all children within the province. This legislation is then translated to provincially mandated professional standards and tools whose primary purpose is to assess the risk and safety of children in their current familial circumstances (Ministry of Community and Youth Services, 2007a; OACAS 2006). Ontario's current model of child welfare is the 'Risk Assessment Model for Child Welfare in Ontario'. The responsibility to implement these provincially mandated responsibilities are assigned to individual workers and departments within the policies and procedures of individual agencies based on geographical jurisdiction.

Similarly, the primary responsibility of the Victim Crisis Unit (VCU) team was also to undertake professional risk and needs assessments in order that they are used to develop treatment and/or safety plans to ensure the wellbeing of their clients (Ottawa Police Service, 2010). Their authority to undertake this task was dictated in their mandate, but it was also supported by a broader federally legislated obligation to victims of crime stipulated in the *Victims Bill of Rights* (Parliament of Canada, 2014). The *Victims' Bill of Rights* (2014) was introduced by the Harper government in order to promote a variety of obligations to victims of crime including the consideration of their needs for treatment and/or remuneration, their right to educated informed on the court process, and their right to have input into the determination of the offender's release. Each of these factors contributes in a different way to a victim's sense of safety and comfort.

My intent in attempting to establish commonality between the VCU and child welfare mandates is important for two reasons. First, I hoped to establish the appropriateness of being able to draw comparisons between child welfare and VCU roles and discuss how each field might inform one another's practice. Specifically, I will discuss the potential role of EI to trauma to formalize and inform apprehensions and placements in child welfare. Relatedly, I thought it equally important to demonstrate that VCU and child welfare workers were both authorized to make the sorts of assessments and interventions that would be required for EI to trauma to be implemented.

Client Populations

A number of commonalities are shared between the population of clients served by the VCU team and the population of children involved in the child welfare system. First, both populations had significant trauma histories, as well as considerable overlap in the types of trauma suffered. For instance, as indicated by Conradi, Wherry, and Kisiel (2010), the majority of child welfare clients have suffered some form of trauma; in fact, traumatic experiences such as physical/sexual/emotional abuse, neglect, and domestic violence are the very factors that illicit their involvement in the system. The forms of trauma identified by Conradi et al. (2010) as common amongst children in the child welfare system are also crimes under the *Criminal Code of Canada* (1985). The literature review also showed that victims of crime also showed a disproportionate amount of trauma in comparison with the general population (Amstadter, McCart, & Ruggiero, 2007; Green, 2007; Ljungwald & Svensson, 2007; McBrearty, 2011). During my time with VCU, clients that were victims of these very crimes were offered and exercised services under the VCU mandate (Ottawa Police Service, 2010).The final area of similarity across victims of crime and the children apprehended by the child welfare system is

that they have both been 'victimized.' While it is quite clear that victims of crime have been 'victimized,' children who are apprehended have suffered first by enduring the protection concern that necessitated their removal from their family and again (potentially) by the act of the apprehension itself.

Early interventions to trauma have been determined to be both effective and ethical for use with children. The Victim Crisis Unit effectively used the principles of early intervention to trauma on a regular basis to support children and adolescents who were victims of trauma and/or crimes. Appropriateness and efficacy of the EI framework with children is also supported by the current literature (Berkowitz, Stover, & Marans, 2011; Kassam-Adams, 2014). In one study, Berkowitz et al. (2011) were able to demonstrate a 73% reduction in predicted diagnostic levels of PTSD in children who experienced traumatic events varying from car accidents, to sexual assault, to witnessing violence. As has been established, both the child welfare system and the Victim's Crisis Unit deal with children who have suffered similar forms of trauma. VCU's current practice and recent literature have both shown that EI to trauma can be used ethically and effectively with children who have suffered the forms of trauma that these two groups of children share. I would therefore propose that it is reasonable to consider that there might be an application for EI with children involved with the child welfare system.

Social Work Practice Environment

In addition to ensuring that there is congruence between agency mandates and client populations, it is also important that appropriateness to compare across practice conditions (VCU and child welfare) is assessed. Through my involvement in both child welfare apprehensions and on-scene VCU interventions, I observed there to be a number of similarities in intervention conditions. Apprehension and on-scene interventions provide an interesting comparison due to

short timelines between the trauma and the clinical support. Both contexts are overseen by a trained professional social worker or clinician. These practice conditions are also similar with regard to the amount of chaos that can be involved. They can each have the interaction of multiple service providers with different perspectives and mandates. For instance, police are routinely used in child welfare apprehensions when the plan for removal is believed to escalate concern for safety of the children, parents, or child welfare worker. Similarly, police also served to support and ensure safety of practice conditions at on-scene VCU interventions. The conditions under which a child welfare apprehension is carried out does have one additional benefit that on-scene VCU work does not – the opportunity for pre-planning. As discussed, child welfare workers are obligated by the *CFSA* (2014) to pre-plan apprehensions whenever possible. This obligation was supported by current research which indicated that planned apprehensions provide a greater capacity to minimize the potential harm caused to family members (Center for Improvement of Child and Family Services Portland State University School of Social Work, 2009). The benefits offered by pre-planning could be mutually reinforced by the introduction of EI to trauma. A planned apprehension would allow for advanced preparation of early intervention plans. Equally, the opportunity to incorporate EI would be facilitated by the advanced awareness that would be afforded by adhering to the necessity of pre-planning.

Reconsideration of Current Gaps in Child Welfare Service under an EI Framework

Above, I have presented my exploration of the similarity between VCU and child welfare mandates, client populations, and practice conditions. This argument was made in order to justify the contention that knowledge learned in the VCU context could be used to improve the child welfare system. Presented below is a re-consideration and analysis of the weakness in the current

child welfare system (as identified in the first chapter of this thesis) that is now informed by my practicum learning.

Prevention of Child Welfare Involvement

As the intent of this thesis is to consider opportunities to used EI principles to minimize trauma once an apprehension has been determined to be necessary, prevention of involvement at the system-level is not directly applicable. This issue was raised in the literature review in order to acknowledge that prevention of involvement in the system itself is the ultimate goal. EI to trauma do offer preventative benefits. The explicit purpose of EI is to assess and mobilize necessary resources in order to reduce a client's suffering and their likelihood of reaching diagnostic level of PTSD or other anxiety disorder symptoms. EI to trauma provide a rare opportunity to work from a position of prevention in a system that is reactive by definition. Both the criminal justice system and the child welfare system are government sanctioned institutions of social control. The criminal justice system is reactive by design. It is triggered only once an individual commits a prohibited act or fails to meet a demand which is demanded of them. Similarly, the bulk of child welfare work is completed once a complaint is received by an agency or only when a family proactively seeks out the support.

Trauma-Informed Child Welfare Practice, Training, and Policy/Procedure

As was stated in the literature review, trauma-informed child welfare practice demands the consideration of a family's previous trauma and their potential triggers in order to understand how involvement with the child welfare system might aggravate pre-existing issues and/or inflict new harm on the family (Conners-Burrow et al., 2013). Conners- Burrow et al. (2013) and Ko et al. (2008) both reported that child welfare workers (on average) suffer from a concerning deficit of knowledge in this area. Despite this concerning acknowledgment, the literature reviewed

revealed no comprehensive training program for child welfare professionals that supported this goal in current practice or under development in Ontario. Provincial government and regional child welfare agencies also failed to translate this into the child welfare tools that are used to action the *CFSA* (2014) legislation (Ministry of Community and Youth Services, 2007a; OACAS, 2006). Repeatedly, the importance of 'trauma-informed' practice was promoted without any methods (education or tools) for reaching this goal.

The founding premise of trauma-informed child welfare practice is ensuring that current post-traumatic symptoms are identified and addressed and that the risk of future traumatization is reduced. This is also the explicit purpose of EI to trauma. EI are distinguished by the fact that they offer concrete instruction and direction. Below, an EI framework will be considered with regard to how it might be applied to both employee education/training and policy/procedure implementation in order to mitigate the current gaps.

An employee training program based on the principles of EI could provide a concrete method to increase both a worker's understanding of trauma and its impacts and to provide that worker with a clinically sound approach to guide their interventions with clients. The impact of such training would be two fold. To successfully adhere to EI in a child welfare context would require that workers are educated on both the general effects of trauma on children, as well as provided with the tools to better understand their individual client and the trauma they are presently enduring or have endured in the past. Apprehending and placing children is an extremely demanding task which requires a multitude of considerations. When undertaking such a demanding task, it is easy to make mistakes or fail to fully consider all relevant factors. Incorporating formal training on EIs may help to reduce the likelihood of these oversights. At the most basic level, this approach would 'force' child welfare workers to consider past and current

trauma for that individual client. In the midst of a verified case of child abuse or neglect, it can be easy to forget that while the act of apprehending and placing a child removes them from one form of harm, it may be triggering another.

It would seem reasonable to suggest that child welfare workers would have the professional capacity to understand and implement this instruction. The academic degrees held by VCU workers were quite similar to those held in child welfare. The VCU workers received training in Early Interventions within their work environment through a combination of structured education and job-shadowing. A similar dual curriculum is also used to train new child welfare workers. The Ontario Association of Children's Aid Society's (OACAS) is the regulatory body that is authorized to provide formal child welfare training in the province of Ontario; early interventions to trauma training could be integrated into one of three primary existing training options offered by OACAS and delivered on an going basis.

As a first option, all child welfare professionals participate in Foundations of Child Welfare Practice training (OACAS, 2009). This is a multi-session training that is typically completed within the first six months of employment. Oddly, no unit of training is devoted to trauma despite the clear recognition of the importance of trauma in the literature (OACAS, 2009; Conradi et al., 2010). Perhaps less surprisingly, but even more concerning, the potential traumatic impacts that the system might cause to clients are also left unattended. This is particularly worrisome with regard to the particularly intrusive power of removal and placement of children. As another option, many Children's Aid Societies provide service to their children-in-care via a specific position called a Children's Services Worker. This position also has a formal training unit that is provided to all new hires as a basis for their integration into child welfare (OACAS, 2011). Finally, the potential negative implications of apprehension and

placement are even ignored in the OACAS advanced curriculum (OACAS, 2009). The OACAS also offer a series of supplementary training courses which provide skill-development opportunities for those further on into their careers. Once again, trauma – both in general and as it might pertain to the influence of the system – is completely absent (OACAS, 2009). The intent of this discussion was to establish that trauma is poorly attended to in the current welfare training system and that there are a number of pre-existing systems into which this training might be included. A more concise explanation of how the EI might be directly applied to apprehension and placement is presented in the further on in this chapter.

It is first necessary to note that educating and sensitizing workers to the importance of trauma is only beneficial if it is implemented into practice with clients; lessons and techniques from the classroom need to be integrated into the field. Cooper, Orrell, and Bowden (2010) reinforced the dual hands-on and classroom learning approach. Workers will require the resources to apply these new techniques in the field and be supported while they develop competency. Another method to encourage this to occur is to have them incorporated them into policy and procedural requirements at a provincial and municipal level. With integration into policy and procedures this not only creates a formal recognition of the level of importance, it also provides an opportunity develop work to assess worker performance and address issues of competence.

The authority to apprehend and remove a child from the care of their parents in the province of Ontario is provided under the *CFSA* (2014). This legislation is translated into a *Standards Manual* (2007) that guides child welfare professionals in carrying out their responsibilities in a manner that satisfies the legislative requirements (Ministry of Community and Youth Services, 2007a). While these tools clearly articulate the conditions that merit the

apprehension , there is no direction at all on how this important and impactful act must be carried out (Ministry of Community and Youth Services, 2007a; OACAS, 2006). Perhaps even more shockingly, I also found that the policy and procedure manual at Family and Children's Services of Renfrew County similarly provides no direction regarding the actual execution of an apprehension or placement (Family and Children's Services of Renfrew County, 1993). Considering the fact that the policies and procedures applicable to apprehension and placement have not been updated since 1993, this is also an indication of the overall lack of current research informing practice. I find this to be a very concerning risk to the quality of service provided to children and families. Without formal direction from a governing body, the expertise with which the apprehension is carried out is solely dependent on the expertise, experience, and/or commitment of that individual child protection worker.

As presented in the literature review, Conradi et al. (2010) observed that valuable information on trauma is being collected under current child welfare practice; however, the quality and usability of information is compromised by poor reliability and validity. Formally integrating an EI to trauma into child welfare practice would offer a standardized framework increasing the consistency of data collection and the quality of the information gathered. In the following section, I have explored how the integration of EI to trauma into this process would help to create a standard of practice that would serve to improve the quality and consistency with which apprehensions are executed.

Applying Early Interventions to Apprehension and Placement

The review of EI literature specified five primary elements of the approach: psychological first aid, risk and needs assessment, safety planning, individualization, and psycho-education. Now that I have had the opportunity to both observe and employ each of these

aspects, I have presented a consideration of their direct application in the process of apprehending and placing children in out-of- home care.

Psychological First Aid

The apprehension and placement of children commonly occurs during a time of considerable chaos and stress. It involves multiple parties and conflicting interests and wishes. Even the practical elements of apprehending and placing children are taxing and demanding. An apprehending worker's duties include, but are not limited to, writing affidavits of apprehension, attending a Justice of the Peace, travel, conferring with police or other service agencies, informing parents, gathering health cards, medications, and belongings, interviewing children, providing explanation to children, and traveling the foster/group placement, and finally providing information the care providers. Any attempt at therapy would be impossible under these circumstances and (likely) counter-indicated during this process both due to the unavailability of worker resources and the level of demand on the child's emotional and cognitive processing.

Attending to a child's needs from a perspective of 'first aid' is much more consistent with what is both needed and manageable at the time. 'First aid' reinforces a focus on immediate safety – both emotional and physical. This would allow prioritization of the many competing duties. The 'first aid' perspective also raises awareness of the need to have enough workers present during the apprehension process. For instance, a two-worker model approach to apprehension and placement would offer considerable benefit to both the parents and the children. A child protection worker would be assigned to attend to the needs of the parents and would work in unison with a Children's Services Worker who would attend to the needs of the children. This is an approach that Family and Children's Services of Renfrew County had

regularly employed but has now fallen out of favour. As a prior CSW, the opportunity to participate in the apprehension provided critical benefits. First, on a practical level it allowed for children to be transported away from potentially physically or emotionally dangerous situations with much greater ease, potentially preventing children from seeing parents lose control or taken into police custody. Second, it allowed the CSW to witness the children's experience first-hand which was a considerable asset to assessing immediate needs and impacts. Ensuring appropriate resources are employed during the apprehension also contributes a more detailed and informed risk and needs assessment which is the next major component of the EI approach.

Risk and Needs Assessment

Prior to the individual components and applicability of this tool being introduced, it must be acknowledged that while the name does not specifically state it, client assets and resources are also included in a risk and needs assessment. This is a critical variable in order to have an accurate assessment of the client's situation. It is equally necessary in order to remain aligned with a strengths-based approach (Sabalauskas, Ortolani, & McCall, 2014). Given the entire argument of this thesis is based on reducing harm, it is imperative that the interventions be conducted in a manner that empowers clients rather than marginalizing them.

The central role played by risk and needs in both the child welfare mandate and the VCU mandate has already been presented. Risk and needs assessment tools are already central in practice with protection clients during the 'investigation' phase (Ministry of Community and Youth Services, 2007b). They are used to determine the level of risk to a child in their current familial circumstances and ultimately contribute to the decision to apprehend. However, while the advantages of assessing risk and need are recognized in making the decision to apprehend, there is no parallel formal assessment of a child's adjustment following the apprehension. If it is

accepted that the apprehension has the potential to be a traumatic experience for that child, it would seem negligent not to have that potential assessed. The components of a thorough EI informed risk and needs and assessment could prove invaluable in the context of an apprehension. An EI risk and needs assessment conducted by VCU was composed of five intersecting components including biographical and contact information, role in the event/proximity to the event, presentation, history of trauma, and personal assets/support networks. An expanded discussion of each of these elements as they might relate to apprehension and placement is provided below.

The accurate and complete collection of biographical and contact information is critical for a number of reasons. First and foremost, it is important that both the assigned worker and the alternate care provider have this information in order to simply 'keep track' of a child and know them as an individual. This component might seem overly simplistic or 'common sense'. However, basic health information such as allergies and medication (which could prove fatal) can be neglected during a volatile apprehension because the attention of protection workers and police are focused elsewhere. The complete and accurate collection and sharing of such information is another factor supporting the inclusion of a 'child-specific' worker in the process of the apprehension.

The translation of a client's 'role in the event' in a child welfare context would correlate to information regarding how a child was removed and their role in the process of this removal. Under the *CFSA* (2014), children can come into the care of a Children's Aid Society via a variety of pathways including abandonment, their own refusal to return to their parents, and removal against their parents' wishes. The pathway to foster or group care could greatly impact a child's interaction with workers and foster parents and perception of their current circumstances.

Children who chose to leave their parents might not perceive their current circumstance as a trauma and may also experience a greater sense of control over their situation than those abandoned or removed. Similarly, the execution of the apprehension can vary considerably in terms of volatility (police involvement, environmental dangers), location (e.g. home, school, police station etc.), duration (e.g. amount of time explaining to parents, gaining possession of children, colleting children's belongings etc.), and time of day (e.g. impacts routines such as bedtime, sports/clubs, family rituals, etc.). Each of these aspects can also impact the risk and degree of potential traumatization. The value of collecting this 'role' information is not simply to have possession of it or for documentation purposes. It is essential that this information guide the manner in which the worker engages with the child and the manner in which the child's reaction is understood.

Information about how a child has responded to being apprehended and observations about their presentation and behavior following that apprehension could be invaluable. As discovered by Ehlers and Clark (2003) and Gray and Litz (2005), individuals who displayed PTSD-like symptoms immediately following a traumatic event were more likely to be formally diagnosed with PTSD or ASD (Acute Stress Disorder). Documenting a child's reaction immediately after and in the days following the apprehension could be beneficial in assessing the impact of the event on their emotional functioning and their potential risk for reaching diagnostic level impacts. It may take a child time to develop a willingness to share directly with workers or care providers, so making note of observations that may indicate the need for intervention is quite valuable. Further, these reactions might also be shared with people who are familiar with the child to determine whether they are typical or atypical ways of coping for that child. As introduced in the literature review, an individual's reaction to trauma can never be accurately

assessed without placing it in the context of any previous traumatic experiences (Spaccarelli, 1994).

The need to understand and account for a child's history of trauma highlights the importance of pre-planning that is already emphasized under the *CFSA* (2014). Knowing what a child has experienced can provide insight both into their previous coping strategies and how this trauma might interact with past traumatic experiences. Spaccarelli (1994) emphasized that trauma cannot be considered in isolation and that tools used to assess trauma must have the capacity to account for this fact. With respect to a child welfare application, a child who has been in foster care before will have different awareness and different needs during apprehension. Other past traumatic experiences (e.g. physical assault, sexual acting out, abandonment, etc.) might also inform appropriate placement options based on the demographic or other factors related to that foster or group home. For instance, children who display sexualized behaviours may not be appropriately placed in a home with more vulnerable children. The completion of a risk and needs assessment that incorporates 'trauma history' along with the other four components of the EI risk and needs assessment helps to satisfy the need to meet the 'transactional' standard for appropriate trauma practice advocated by Spaccarelli (1994). Transactional, as defined by Spaccarelli (1994), means that that the tools used must have the capacity to use the individual's history of trauma to understand their current presentation and reaction and can also provide insight into their current interaction with service providers (in this case child welfare workers).

Best practice guidelines for child welfare and EI also demonstrate compatibility with regard to their shared emphasis on a client's right to be self-determined and empowered during the involvement in the process and the need for collaborative acknowledgement and cultivation

of that client's individual strengths and support networks (Amstadter et al., 2007; Devilly et al., 2006). Amstadter et al. (2007) indicated that an individual's coping mechanisms were the most significant factor in determining his or her successful processing and resolution of a traumatic event and avoidance of diagnostic-level symptomology. A commitment to empower children and these principles already exists in the child welfare context. For instance, a Youth Leaving Care Working Group (YLCWG) was initiated by the Ministry of Community and Youth Services (MCYS) in order to gather feedback and instruction from young people who have had direct involvement in the system (YLCWG, 2013). The YLCWG created a report for the MCYS in which they provide their specific recommendations. While this initiative is in itself a demonstration of the commitment to involving youth in their own identification of their wants, needs, and abilities, the principles that they cited as central to their report were also strengths-based, partnership, and anti-oppressive (Youth Leaving Care Working Group, 2013). Additionally, the MCYS's recognition of the importance of natural social networks and relationships was discussed in the literature review with the discussion of the shift toward an imposed obligation to demonstrate efforts to locate kin-based options for care (Government of Ontario, 2011). These developments would appear to be indicators to self-determination and prioritization of personal assets and existing support networks by the MCYS, elements that are also equally critical in early interventions to trauma.

Integrating EI to trauma at the time of an apprehension would be another opportunity to propel this movement forward. Specifically, children could be offered age-appropriate ways to reflect on what mechanisms they have employed in the past in times of stress. They would likely also provide valuable information on supportive extended family and other community or cultural figures who might offer a sense of comfort and familiarity; in some cases, these might

also be options for placement of that child. Involving and engaging children/youth in a discussion regarding their own strengths, assets, and their support networks can not only be important for the practical implications, but it would also provide an opportunity for rapport-building. Children who have had apprehension 'inflicted' on them based on a worker's judgment of their parents' actions or inaction can be incredibly disempowered. This disempowerment occurs in addition to the potential embarrassment, self-blame, and/or injury of the abuse and/or neglect that they may have suffered. The opportunity to use an empowering, strengths-based approach to help a child play a pivotal role in their own coping could provide exceptional value both with regard to their own empowerment and their engagement with adults who will make impactful decisions about their lives.

An exhaustive needs and risk assessment is essential but not sufficient; for the benefits to be fully realized, these must be translated into action and with particular attention to safety planning. As such, apprehension and placement safety considerations as assessed by EI to trauma are provided in next section.

Safety

The purpose of a rigorous, well-executed risk and needs assessment under an EI framework is determined by its ability to produce a comprehensive safety plan attuned to that client's individual needs. A 'safety' plan in this particular child welfare context could vary considerably based on the individual child's needs. The reality of some apprehensions and placements is that there are legitimate safety concerns for all parties involved. The foster home or group home where children are placed might need to be kept from some of their family members when there are significant concerns of violence. Alternatively, some children present a risk to themselves through suicide or self-harm.

Safety in the context of apprehension and placement would more commonly refer to emotional well-being. As raised by Sammut (2011), disruption of significant attachment relationships, community, school, and friends can be a significant emotional trauma, which can compromise mental health and development. Safety-based aspects of the apprehension and placement could pertain to the selection of an appropriate foster home (proximity to hospital or other mental health resources, vulnerability of other members of the foster family, expertise of the foster parents etc.), access of counseling services, and developing visitation plans with biological family members.

In this general discussion of 'safety planning,' it is impossible to introduce every detailed plan that might be developed because the content will be determined by that individual child. The commonality amongst all safety plans that are aligned with an EI perspective would be that they are to be developed by a child welfare worker whose attention is now attuned to safety and action. Both the planning and the actions would be conducted with the age-appropriate involvement of the child, with a focus on pre-existing strengths and assets that can be monopolized for that child, and with attention to the particular individual safety/well-being needs of that child (both for the present and for the immediate future).

Psychoeducational

The psychoeducational component of an EI-informed child welfare apprehension might occur at both the case and system level. In its most traditional form, the psychoeducational part of EI to trauma refers to the normalizing of certain factors that are commonly experienced after a trauma and education on the resources and systems with which that client may become involved due to their traumatic experience. This was an opportunity for the client to ask questions and gather information about what to expect.

At this individual level of the apprehension and placement process, the EI application would involve the child welfare worker and foster parent providing age and capacity (e.g. accounting for learning delays) appropriate information to a child on what they might expect over the coming days. This 'education session' would be driven by the child's questions and needs and would not introduce any concepts or information that might contribute to further symptomology. This application could be implemented to address both the incident of abuse or neglect that provoked the removal and/or the placement process itself. Children who have been removed from their parents tend to have many questions about what is happening and what will happen next. They, understandably, tend to be fixated on when they will see their parents next or when they will go home. Care providers and workers need to be prepared to attend to these questions will the fullest, age-appropriate information possible. This can be a particularly trying task when there are considerable unknowns. Many times a great part of the psychoeducation becomes around improving children's capacity to manage this uncertainty. It is particularly important that children receive information directly because their entire known environment has been taken from them, and they have been forced into the difficult position of having to rely on strangers. These strangers not only have care and control over them, but they also have considerable intimate information about the personal lives and families.

It is imperative to reiterate a caution that the child's appreciation and interpretation of the event should guide the specifics of this (and all) aspects of the intervention. Some children will not appreciate either the incident that brought them into care, or their removal/placement as a trauma (Balaban, 2006). Both social workers and foster parents will both need to have a sense of confidence and competence. The manner in which they provide support to the child will likely vary. Information that was gathered in the rest of the intervention would need to be shared with

the care provider in order that they are able to meet that specific child's needs appropriately. As they are tasked with providing day-to-day care to children, foster parents may in fact have more opportunity to integrate trauma supports in a naturalized setting. For instance, Dyregrov and Regel's (2012) provocative discussion of the use of video games and movies to disrupt memory formation would be accessible to foster parents. Additionally, they might also employ physical interventions such as the trauma releasing exercises described by Berceli and Napoli (2007); as these could quite easily be incorporated into indoor or outdoor play. This form of trauma-informed approach could also promote teamwork between professional staff and care providers. While the introduction of innovative and holistic approaches to treating trauma offer an opportunity to engage a wider 'treatment team', it is essential that the exact methods used are dictated by that specific child's needs. Furthermore, the need for this wider network of care providers to attend to the sophisticated psychoeducational elements of EI to trauma again reinforces the need for improved training and education across professionals and non-professionals.

At the systemic level, training sessions on the effects of trauma could be offered for adults who regularly work with children-in-care. Child welfare workers are highly-educated, professionals who work in a field that is considerably impacted by trauma (Conradi et al., 2010); yet the research shows that there is substantial deficit in their knowledge of trauma and its impacts (Ko et al., 2008). Based on this fact, it is also reasonable to suggest that many other members of the broader child welfare system (e.g. group home staff, foster parents, volunteer drivers, case aids, etc.) might equally benefit from improving their knowledge base. These sessions could provide generalizations about what is to be expected, normal reactions to trauma, and indicators that additional professional support might be required.

Individualization

A clinically sound intervention consistent with EI principles is characterized by being individualized, and it is central to carrying out each of the other components of this framework. A number of factors contribute to individualization. First, this approach has a heavy emphasis on information gathering. Information is gathered about the individual, their personal assets and resources, their current state and functioning, and their trauma history. Second, significant value is also placed on the client being as involved as possible in the collection of information, its interpretation, and the resulting plan. Just as adults have unique personalities, interests, talents and vulnerabilities, so do children. Clinicians and other supporters must resist the urge to consider children only by their age and/or gender because these factors alone are not sufficient to qualify as individualization.

Individualization is difficult to describe in general terms in this context, specifically because it is designed to be tailored to the particular characteristics of that client. In a child welfare context, common considerations might include such aspects as the amount of information shared, the appropriate type or form of counseling, inclusion of specific strengths and areas of vulnerability, and continued attention to the child's role in determining their own plan. Elements of the apprehension/placement process that might be considered for individualization are where the child is apprehended form, time of day, or who delivers the message that the child will be coming into care.

Conclusion

Based on the illustration described above, together the five elements of an ethical and effective early intervention to trauma appear to be compatible with both the theoretical foundation and the practical applications of child welfare practice in Ontario. The integration of

early intervention to trauma could offer the opportunity to contribute to the resolution of the current gap between the acknowledgement of the importance of trauma and the inadequate education and direction that is currently offered to those who practice within the system.

Chapter Five

Ethical Considerations and Concluding Thoughts

Two primary areas of this thesis required ethical consideration. The first was with respect to the actual participation in my thesis and direct engagement with clients of the Victims' Crisis Unit. The second significant area of ethical consideration pertained to the content of the previous chapter of this thesis and the consideration of concern about the current state of child welfare practice in this province.

Practicum Ethics

I completed an advanced practicum under the guidance of a pre-existing supervisor agency (VCU) and was not required to present before the Research Ethics Board at Laurentian University. Maintaining a high level of commitment to ethical practice remained very important. As a social work student, I strove to attend diligently to all of the requirements of the Ontario College of Social Workers and Social Service Workers in the *Code of Ethics and the Standards of Practice* (2008) and the Canadian Association of Social Workers *Code of Ethics* (2005) and *Guidelines for Ethical Practice* (2005).

There was a particular need for close consideration of the standards of ethical social work practice due to the vulnerability of the population of VCU clients. As indicated, VCU clients tended to be from populations marginalized by poverty, cultural oppression, racism, and mental/physical health concerns. Furthermore, they had also 'just' endured a potentially life-altering trauma such as the death of a family member, severe physical or sexual assault, or witness of extreme violence or carnage. The privilege of working with this group of clients required specific ethical attention in a number of respects.

First, I made efforts to remain cognizant that working with such clients requires additional attention to obtaining legitimate, informed consent. Butters and Vaughan-Eden (2011) noted significant concern about the ability of some traumatized victims of crime to consent to service that they made suggestions regarding the revision of the *Code of Ethics* to better reflect issues of compromised emotional state and freedom to refuse service. Second, I was also mindful of the findings regarding the prejudicial treatment that some victims of crime received from law enforcement officers and social workers (Cooper, Anaf, & Bowden, 2008). I tried to ensure that I placed extra effort towards engaging with my clients because of my awareness that they may have been disregarded or judged by other professional service providers in the past. Interestingly, I found that the vast majority of clients were eager to have their session with the VCU worker and to be referred to services that were appropriate. This was perhaps reflective of Dyregrov and Regel's (2012) observation that even in the midst of this current tragic life experience, people continue to reach out for support.

Beyond ensuring ethical direct-contact with clients of the VCU, I am appreciative of the fact that this practicum has also helped me to fulfill some of the other ethical obligations bestowed on social workers such as maintaining professional competence and promotion of social justice (CASW, 2005). To date, I have worked almost exclusively within child welfare. This has limited my ability to engage in direct-practice, as child welfare roles tend toward a more case management approach. I am so pleased to have had the opportunity to engage in a placement that allowed me the opportunity to improve my skills as a clinician. I also found the opportunity to work in a capacity that helps to mitigate and/or prevent the negative ramifications of trauma truly inspiring.

Having now completed my practicum, I find that the most important ethical obligation moving forward is to use the privilege of this learning opportunity to contribute to empowering the lives of the clients with whom I work each day. I have addressed this ethical obligation below by providing a discussion of the ethical implications of the consideration of apprehension and placement as a traumatic event that I discussed in the previous chapter.

Ethics and the Child Welfare System: The Critical Need for Change

It is insufficient to provide an argument about how the child welfare system might minimize the potential trauma it inflicts without also providing a rationale as to why there is a burden to fulfill this goal. Quite simply, it is impossible for child welfare agencies to successfully fulfill the requirements of their mandate without accounting for the impact of trauma. Ontario's child welfare system evaluates its service to children based on its ability to support their well-being, safety, and permanency (OACAS, 2010). Trauma can intimately and profoundly impact each of these areas, and consequently, it is also a critical factor in child welfare agencies' ability to support children and in achieving these objectives (well-being, safety, and permanency). Ko et al. (2008) identified that most child welfare workers are aware that the majority of their clients have suffered complex and chronic traumas; however, the researchers also determined that workers are much less knowledgeable about how these experiences impact a child's daily emotional, behavioural, and social presentation. Potential mechanisms by with EI to trauma might be used to address this deficit were explored in detail in the previous chapter of this thesis but briefly stated, they result from a combination of increased training, better assessment and identification, and a trauma-sensitive child welfare system.

At the risk of sounding callous, it is also critical to acknowledge the need for fiscal responsibility. Child welfare (while arguably very underfunded) is a considerable investment of

tax dollars. The 2012-2013 annual budget for child welfare service in Ontario was in excess of 1.4 billion dollars (OACAS, 2013). It is imperative that these dollars be used in the most effective and efficient manner possible. This means that the issues contributing to child welfare concerns need to be thoroughly understood so that funding can be appropriately allocated. As Conners-Burrow et al. (2013) identified, currently most child welfare programs and training are poorly evaluated and the results of the evaluations, when they do occur, tend to be poorly disseminated.

It seems redundant, both intuitively and logically, to conceive of a circumstance in which the average, reasonable person would not deem it essential that government interventions not cause trauma to innocent children. This is particularly true of a governmental agency whose purpose is to protect those very children. However, the time has been taken here to do so due to the higher obligations that are bestowed on social workers. Above and beyond the ethical obligations of the 'average' person, the Canadian Association of Social Workers (CASW) places professional and ethical obligations on social workers which it considers critical. These include two obligations which are perhaps most directly related to the issue of trauma-informed child welfare practice: to ensure the competency of their training and practice and to devote themselves most fully to empowering and supporting vulnerable, marginalized clients (CASW, 2005). The duty of competency would require that social workers remain aware of the literature on trauma and the newly available methods of improving their engagement with clients (CASW, 2005). The vulnerability of children, particularly those from deprived and abusive environments would trigger the duty of social workers even before the potential for further traumatization by the system. However, to be complicit in a system that potentially inflicts harm is contrary to the very core of social work ethics (CASW, 2005).

Concluding Thoughts

This thesis has a number of limitations that require acknowledgement and discussion. As the first two goals of this thesis related to my own learning experience and development, limitations pertain mostly to my critical analysis and assertions related to the appropriateness of EI to trauma to reduce the potential traumatic impacts of apprehension and placement of children (the final goal of this thesis). The limitations are identified and discussed below in the interest of full transparency.

It is important to acknowledge that this practicum and thesis first sought to establish the legitimacy of considering the process of apprehending and placing children as a potential trauma for those children. As indicated in the literature review, my search uncovered that there was a complete deficit in that evaluation of the potential negative impacts of child welfare apprehension and placement. The lack of academic research in this specific area required that my search be widened. While there were indications of harm at this broader level, the necessity to expand the search could be seen as weakening the foundation of the arguments that I put forth because those results were not explicitly connected to the process of apprehension and placement. Without question, I would see the rigorous, empirical evaluation of the potential harm of the child welfare system's execution of apprehension and placement as imperative in future research. Additionally, my consideration of the potential trauma of apprehension and placement should not been seen as an assertion that the relationship is absolute. Due to a variety of reasons, some children will be much less affected by the process, and some might even be positively impacted.

Suggestions made about the appropriateness of applying EI to trauma in the process of apprehension and placement of children could also be compromised by the same deficits in

literature identified above. This appropriateness of this argument is completely reliant on establishing that apprehension/placement can be traumatic; if this relationship is disproven, the need to integrate EI to trauma becomes moot.

My discussion of the appropriateness and usefulness of EI techniques are subject to a number of other cautions which relate much more directly to my own skill level and ability. Without question, I am a complete novice with regard to emergency driven trauma care. I have minimal experience with the EI techniques and was exposed to these techniques in a new practice environment. The limits of my experience and comprehension of this skill set could easily have led to poorly conceived or inaccurate conclusions. Additionally, even with the acceptance of a role for EI to trauma in child welfare, the manner in which it is incorporated might be different than suggested here. Finally, even if the assertions made about EI to trauma and apprehension and placement are validated, the analysis for application in this thesis would be required to undergo further research and advancement to be developed into a comprehensive curriculum and professional practice tools.

Finally, I have focused exclusively on the potential trauma inflicted on children who are apprehended and placed. There are many other individuals who are affected by the child welfare system both directly and indirectly, such as biological parents, foster parents, children of foster parents, and child welfare workers. The exclusive focus on children should not be viewed as an assertion that others are not also at risk of harm. In fact, secondary trauma is a well-established phenomenon amongst social workers working in the child protection field, making it even more plausible that others more directly impacted (parents, siblings, foster parents) might also be negatively affected (Bride, 2007).

I have chosen to remain focused on children-in-care because of their particular vulnerability and the extent to which their lives become disrupted. As established in the child welfare literature review, children are particularly vulnerable not only due to specific characteristics that they hold as a population, but also to enduring the process of being apprehended and placed. Children who come to the attention of child welfare agencies tend to share characteristics such as higher level of mental health concerns, lower educational achievements, and higher levels of poverty which make them particularly vulnerable and marginalized (Bruskas, 2008). The very factor that triggers child protection concern was related to a traumatic experience for a child (Ko et al., 2008). They are also the party that undergoes the actual removal from the surroundings and people that they are familiar and placement in out-of-home care. Due to their developmental level, children may have greater difficulty understanding this process which can exasperate the negative impact (Balaban, 2006; Bruskas, 2008). As presented, both elements of this experience can have significant negative implications for their attachment, development, and safety (Mennan & O'Keefe, 2005; Sammut, 2011; Troutman, 2011).

In addition to the characteristics of the children themselves that determined my desire to focus on them, this decision was also made based on my own personal reasons. Children-in-care are the population with which I am most experienced. I have worked the majority of my career in child welfare (10 of the past 12 years) working directly with children in care. This is a population of which I feel I have the most knowledge. Furthermore, they are also a population to which I am uniquely inspired by and devoted to.

Conclusion

The opportunity to engage in the prevention of 'harm' or trauma is extremely important to me personally and professionally. While it is a great privilege to work in the social work field which is devoted to the supporting clients to overcome the hardships and injustices that they have endured, it is the opportunity to work in a preventative capacity that I find truly inspiring. This desire became particularly poignant for me in my capacity as a child welfare worker because of my growing concern that the system was inflicting harm on our clients. I found it intolerable that I would recognize the potential trauma being inflicted and not make an attempt to improve this issue whether that solution is at my own individual and/or systemic level of practice. It was this discomfort and desire for change that propelled me to embark on this particular thesis.

The intent of this practicum, and the resulting thesis, was to provide an opportunity to improve my capacity to support clients affected by trauma. My approach to undertaking this task was to develop three primary learning objectives which I saw as critical to successfully achieving this end. The first goal I defined was a desire to gain, through experiential learning, the ability to understand and implement early interventions to trauma in an effective and ethical manner in order to minimize the impact of victimization and trauma. The second goal I created was to make an overall improvement to my capacity as a trauma clinician by using mindfulness to nurture my therapeutic presence, client engagement, self-awareness, and professional self-care. The third and final goal was to critically analyze the potential benefits that early interventions to trauma might offer for reducing the trauma inflicted by the child welfare processes of apprehending and placing children in out-of-home care. The first two learning goals were largely addressed together throughout this thesis, as they both related to the improvement of my personal social

work practice. The third goal, in contrast, was addressed primarily on its own in the fourth chapter. This was due to the fact that it was undertaken after the completion of my practicum placement. I approached the critical analysis of the processes of apprehending and placing children as a reflective process. The overall process of writing this thesis document was supportive of my 'experiential' learning in that if provided me the opportunity to engage with all of the learning that I had completed for my practicum experience, including the preparatory literature reviews.

Chapter one of this thesis document presented the three literature reviews which formed the foundation for both my practicum experience and this document. The first of these reviews focused on victims of crime and early interventions to trauma. This literature review improved my awareness of the current trends in victim-focused service delivery, the characteristics that tend to define victims of crime as a population, and the specific skills that were identified to be essential for social workers engaging with victims. It also highlighted the EI components that are associated with best-practice (psychological first aid, risk and needs assessment, safety planning, psychoeducation, and individualization). This knowledge served a preparatory function for my role as a VCU practicum student. The second literature review, contained in this same chapter, centred on mindfulness practice. I specifically focused on the literature related to mindfulness and its ability to support preventative self-care for social workers in order to reduce the risk of vicarious trauma. Additionally, I also used the mindfulness literature to develop my knowledge of how mindfulness might improve the therapeutic engagement between client and clinician. The academic knowledge that I gained regarding mindfulness in this capacity was used to inform my active practice of these techniques during my practicum learning experience. Finally, the third literature review which provided an exploration of child welfare literature on apprehension and

placement was somewhat differentiated from the previous two presented. This difference was due primarily to the fact that my initial search uncovered that there were no current, academic resources attending to the potential negative impacts of apprehension and placement. As such, I broadened my search and drew in other areas of research that sought to substantiate the potential trauma caused. The completion of this literature review served as the initiation of my formal assessment of my contentions about the aforementioned child welfare processes.

The second chapter introduced my practicum environment and also provided a description of my specific practicum goals. I intentionally pursued the Ottawa Police Services, Victim's Crisis Unit as my practicum environment because of the excellent learning opportunity it provided. The VCU team uses EI to trauma on a daily basis to serve those that have been impacted by a crime or trauma. This placement afforded me the opportunity to observe these techniques in practice and the chance to engage them in my own practice under the guidance of an experienced expert. After providing the description of my practicum environment and its functioning within the OPS and the greater network of social service delivery, I introduced a more detailed presentation of my three learning goals as they would relate specifically to the Victim's Crisis Unit.

In chapter three, I shared the most memorable experiences and activities that I undertook in my role as a VCU placement student. I also presented my considerations about how these experiences interacted with my learning goals and with the academic knowledge that I had carried into my practicum environment from my review of the literature. This chapter provided me the opportunity to reflect and appreciate the whole of the learning that I participated in and documented in my daily journals. As I also identified in that chapter, the privilege to be in a purely 'learning' role was a vital and invigorating reward at this point in my career.

The fourth chapter of this thesis introduced my critical analysis of the appropriateness of EIs for the prevention and/or mitigation of the traumatic implications of apprehending and placing children. First, I attempted to establish that the similarities between the VCU and child welfare practice contexts allowed for comparison between the two and set the stage for one to inform the other. Upon this analysis, I introduced the manner in which EI to trauma might address some of the current ways that the child welfare system fails to appropriately integrate trauma-informed practice. Finally, I provided a detailed description of how EI to trauma be practically applied in the context of an apprehension and placement in order to raise awareness of trauma and mitigate its potential impacts.

The fifth and final chapter of this thesis provided the ethical considerations, the limitations of this thesis, and finally this overall conclusion. The ethical concerns for this thesis related to two primary areas, my obligation for ethical practice with VCU clients and the ethical implications of my argument regarding the harm inflicted by the child welfare system. The limitations of this thesis are presented as an acknowledgement of how the gaps in current research and my own inexperience might undermine the arguments that I have presented. Rather than highlighting weakness, my hope is that presenting these limitations will encourage further research and assessment of how child welfare might be conducted in a more ethical and effective manner.

As I reflect on the whole of my practicum experience, both my personal and professional vantage points have been significantly changed. From a personal perspective, I have come to be much more present and self-accepting. My ability to be present in a moment had grown exponentially through this process. From a professional perspective, I came to realize that some of my learning objectives proved to be difficult, irrelevant, or unattainable. However, I remain

committed to my opinion that the child welfare system can cause trauma to the children and families that it is intended to serve. While I believe that there is a foundational argument in favour of considering how EI trauma might better inform the apprehension process, I have also accepted that the amount of additional research required far exceeds the capacity of this Master's level thesis. I take personal and professional comfort in the fact that I can, regardless of the state of the broader child welfare system, approach my work in a manner that seeks to prevent harm to my clients, and I am hopeful that this exploration of trauma and child welfare practice might inspire others to push forward with more sophisticated research or, at minimum, consider the manner by which they carry out their child welfare responsibilities in a more trauma-sensitive manner.

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Appendices

Appendix A – Outline of Learning Goals

Practicum Objectives: Early Interventions to Trauma and Mindfulness

Objectives	**Tasks**	**Supports and Resources**	**Achievement Indicators**	**Timeline**
Learn the mandate of the VCU	Obtain and read the literature provided to new VCU workers during orientation.	VCU mandate, Ottawa Police Service VCU counselor job description	Ability to understand and work within mandate and respect boundaries of position, while supporting	September 22, 2014
Learn about the role of VCU as a part of a multi-systemic service delivery (both internal to OPS and in broader community)	1. Gather information from VCU workers about working within the Ottawa Police 2. Obtain information about the rational for locating the victim's services within OPS 3. Become familiar with community-based supports for victims of trauma	Supervisor, and members of the VCU team Gather a database of literature & community awareness campaigns	Ability to provide information to clients with regard to a variety of community resources (domestic violence, mental health, grief support etc.) Effective and efficient referral to community support services for clients of VCU Understand the rational for locating VCU within the OPS.	November 2014

			Positive relationship and rapport with common community partners	
Learn EI strategies used by VCU workers and how they are applied	1. Gain a thorough academic understanding of early interventions to trauma including development, parameters, debates, cautions, literature deficits 2. Gather and read any internal VCU materials on EI techniques 3. Observe members of the VCU team in their application of EI techniques	LU databases, online research for academic journals Ottawa Police Service documents, instruction manuals Direct observations and maintenance of a daily journal	Thorough knowledge of all relevant and current literature on EI and trauma Ability to describe in detail methods use by VCU. Positive appraisal by VCU members of demonstrated abilities with clients.	By completion of practicum - November 2014
Improve ability to build rapport and trust quickly, under stressful circumstances	1. Build knowledge of desirable clinician presentation for VCU workers. 2. Observe and participate in	VCU team members VCU supervisor	Appraisal/feedback from Practicum Advisor and VCU team members Willingness of VCU clients to	On-going

with traumatized/fragile clientele	peer-supervision to gain feedback on performance. 3. Continue to develop self-awareness, implications of social location, cross-cultural perceptions. 4. Feedback from Practicum Advisor regarding advanced social work practice	Guidance of First Reader (Diana Coholic) Review and practice with Mindfulness literature and resources	engage with me as a clinician	
Develop ability to complete an accurate and useful Needs and Risk Assessment	1.Review needs and risk assessments (requirements, content, purpose) completed by members of VCU 2. Practice preparing risk and needs assessment compatible with principles of EI under guidance of VCU professionals, receiving constructive feedback	Risk/Needs Assessment documents from VCU VCU Practicum Advisor	Positive Evaluation and approval of Need/Risk Assessments by VCU team members and Practicum Advisor	November 2014
Personal Reflection and On-going Self	1. Maintain daily mindfulness journal of experiences to allow time to process work,	Mindfulness Journal	Increasing ability to identify when risk of deviating from practice	November 2014

Awareness	approach, adherence to worldview, social work perspective, and practice intervention 2. Engage in supervisions with VCU Practicum Advisor for time to critically reflect on work and practice when not engaged in field work.	Clinical Supervisor	Increased ability to critically analyze own work and then make further adjustment	
Individualization of services, special populations	1. Develop cultural sensitivity/capacity/knowledge with populations in Ottawa community and served by VCU. 2. Learn how VCU tailors their services by specific population group (gender, culture, language, age).	Information from cultural centres Previous professional experience with working with traumatized children	Have basic knowledge and understanding of cultural groups working with VCU and culturally appropriate resources in community Capacity to have individuals share their personal culture Relationships with culturally based service providers in community Ability to adapt to a greater number of language/cultural barriers	November 2014

Worldview	1. Become adept remaining true to my worldview (participatory/advocacy) while practicing social work in a demanding, crisis-based environment	Mindfulness Journaling (self-reflection and processing) Meditation	Clients empowered while processing through traumatic/tragic event Clients central to dictating their own intervention plan	January 2015
Strengths-Based Perspective	1. Remain cognizant of remaining aligned with principles of Strengths-Based social work under strained and emergency situations 2. Learn to support clients in identifying their internal strengths and capacities 3. Develop the ability to help support clients in engaging with their natural support networks	Social work Codes of Ethics (Ontario College of Social Workers and Social Services Workers) Research and reference texts regarding Strengths-based perspective	Clients feel knowledgeable and empowered in criminal justice system Clients maintain complete identity throughout my intervention (not victim only) Clients are able to identify and mobilize their own inner assets and pre-existing support networks	On-going November 2014
Practice Model -	Drawing on a foundation of	Academic	Positive feedback under	Mid

Early Intervention	academic research and observation, develop the ability to practice EI methods in a manner that is effective, ethical, and aligned with my personal worldview	research materials VCU training materials Practical experience and knowledge of Practicum Advisor and other VCU team members	observation/supervision of VCU team members Confidence of VCU Practicum supervisor to allow direct engagement with clients Comfort with implementation of techniques	November 2014
Clinician Considerations	1. Inquire & review organizational practices/design. 2. Maintain appropriate self-care with the support of Mindfulness	Organizational practices (peer supervision, peer support) De-briefing with Practicum Advisor Yoga and gym membership Time with	Remain physically healthy (minimal cold, flu, etc.) Sleeping well. No anxieties or intrusive thoughts related to placement. Alert and energetic.	January 2015

		friends and family Nutrition journal Hill (2013)		
Critical Analysis: Child Welfare Applications				
Objectives	**Tasks**	**Supports and Resources**	**Achievement Indicators**	**Timeline**
Continue to explore, analyze, and synthesize literature on trauma informed child welfare practices	1. Continue to monitor and collect new literature on academic data bases 2. Continue to review literature and reflect with new practicum experiences	Laurentian University – Libraries website Google Scholar First Reader (Diana Coholic)	Familiarity with any/all current literature on trauma informed child welfare practice, any literature on trauma caused by child welfare system, and training requirements for child welfare professionals	Ongoing, January 2015
Gain understanding of	1. Review OACAS Standards Manual, CFSA	OACAS Website and	Thorough understanding of provincial expectations of child	January 2015

OACAS policy, procedures, and standards for apprehension of children		materials CFSA	welfare agencies	
Develop expertise with internal policy and procedures informing apprehensions at FCS Renfrew County and other Children's Aid Societies	1. Review policy and procedures regarding apprehension of children by authorized protection workers in Renfrew County 2. Obtain and review parallel materials from other child welfare agencies to evaluate for similarities and differences	Child Welfare policy and procedure manuals	Ability to discuss clearly the expectations of protection workers at my home agency Ability to identify commonalities/difference across other jurisdictions	January 2015
Discussion and determination of potential integration	1. Integrate all knowledge collected on child welfare apprehension (research and practice) and EI techniques with trauma (practicum and research) 2. Critically analyze my findings in a formal written form.	Work experience Practicum experience Research materials Critical analysis skills	Completion of thesis section of practicum with a formal analysis and personal conclusions about the appropriateness/inappropriateness of EI techniques to minimize trauma in child welfare practice	January 2015 (end of fall semester) for planned completions of MSW requirements